Attachment A: Quarterly Staff Credentialing Reporting Form

Quarterly Reporting of UM Staff Credentials

LME:

QUARTER/YEAR: QYYYY

Date: MMDDYYYY

Name (Last, First)	Highest Level Degree (MD, DO, PHD, MA, MS, MSW, BA, BS)	Major or Field of Study (eg., clinical psychology, agency counseling, social work)	License Type (eg., MD, LCSW, LSAC)	License Expiration Date MMDDYYYY	License Number	Years Experience			Hire Date MMDDYYYY
						MH YY/MM	SA YY/MM	DD YY/MM	

ADM002 Rev11032008 1 of 1

Attachment B: Residential Childcare Facility Level II, III and IV Medicaid Provider Log

Medicaid Provider Number	Facility Site Address	License Number	Bed Capacity	Tx Level	License Effective Date	License Expiration Date	Endorsement Effective Date	Endorsement Expiration Date	Effective Date In MMIS	End Date in MMIS	Status
66XXXX1	Provider Name Provider Address Town, NC 12345	MHL-XXXXX1	4	II	2/25/2008	12/31/2008	6/19/2007	6/19/2010	10/1/2000	1/1/2009	New
66XXXX2	Provider Name Provider Address Town, NC 12345	MHL-XXXXX2	4	III	1/1/2008	12/31/2008	12/14/2006	6/30/2010	10/1/2000	1/1/2009	Renewed
66XXXX3	Provider Name Provider Address Town, NC 12345	MHL-XXXXX3	6	II	1/1/2007	12/31/2007	12/12/2006	12/12/2009	10/1/2000	1/1/2008	Closed
66XXXX4	Provider Name Provider Address Town, NC 12345	MHL-XXXXX4	4	III	1/1/2007	12/31/2007	12/12/2006	12/12/2009	10/1/2000	1/1/2008	Terminated

Attachment C: Service Request Form

To be provided at a later date.

Attachment D: Criterion 5 Service Needs/Discharge Planning Status Form

Criterion #5 Service Needs/Discharge Planning Status Form

In order for this form to be processed, all blanks must be completed and legible.
[Insert LME Name & FAX # here]

Client Name:	Date of Birth:	Age:	Medicaid#:
Admission Date:	Decertification Date:	Current Placement:	
County of Residence:			

Complete when requesting initial authorization

Check if Needed	Service	Service Available		If no, Anticipated Date of Availability
	Outpatient Treatment: ☐ Individual; ☐ Group	**Yes**	**No**	
	Community Support: ☐ Individual; ☐ Group			
	Assertive Community Treatment			
	Day Treatment			
	Residential Treatment Level I			
	Residential Treatment Level II			
	Residential Treatment Level III			
	Residential Treatment Level IV			
	PRTF (Psychiatric Residential Treatment Facility)			
	Psychiatric Evaluation and Treatment			
	Respite			
	SAIOP			
	SACOT			
	Other (Identify):			
	Other (Identify):			
	Other (Identify):			

Update Information

Date	Client Status	Service Required (Checked Above)	Steps Taken to Obtain Necessary Service	Anticipated Date of Availability

Is the patient at risk of decompensating if services are not available: ☐Yes; ☐No
Explain stating specific behaviors:

Signature/Title: _____ Date: _____

Print Name: _____ Telephone: _____ FAX: _____

I have reviewed this form and I am aware of the efforts that the Area Program is undertaking.

Hospital: _____ Signature/Title: _____ Date: _____

UM003 Rev11032008

Attachment E: Certifications of Need for Inpatient Admissions for Recipients under the Age of 21

Psychiatric Residential Treatment Facility Certification of Need: Medicaid Inpatient Psychiatric Service Under Age 21

North Carolina
Department of Health and Human Services
Division of Medical Assistance
Clinical Policy and Programs
2501 Mail Service Center - Raleigh, N.C. 27699-2501

Michael F. Easley, Governor
Dempsey Benton, Secretary

Tara R. Larson, Acting Director

Psychiatric Residential Treatment Facility
Certification of Need: Medicaid Inpatient Psychiatric Service Under Age 21

Recipient Name: _____ Facility Name: _____

Medicaid ID #: _____ Provider #: _____

Date of Birth: _____ Admission Date: _____

Type of Certification: (check 1 item)

☐ Pre-admission/elective

☐ Emergency admission

Medicaid Eligibility Status: (check 1 item)

☐ Medicaid eligible on admission

☐ Pending Medicaid on admission

☐ **No evidence of Medicaid on admission**

☐ Applied for Medicaid during stay

☐ Applied for Medicaid after discharge

At the time of admission, the interdisciplinary team certifies the following:

1. Ambulatory care resources in the community do not meet the treatment needs of the recipient.

2. Proper treatment of the recipient's condition requires services on an inpatient basis under the direction of a physician.

3. The inpatient services can reasonably be expected to improve the recipient's condition or prevent further regression so that services will no longer be needed.

_____	_____	_____
Physician Team Member Signature	Print Name/Title	Date (Mo/Day/Yr)
_____	_____	_____
Other Team Member Signature	Print Name/Title	Date (Mo/Day/Yr)

Submit to: [Insert LME Information Here]

UM005 Rev11032008

Certification of Need: Medicaid Inpatient Psychiatric Service under Age 21

North Carolina
Department of Health and Human Services
Division of Medical Assistance
Clinical Policy and Programs
2501 Mail Service Center - Raleigh, N.C. 27699-2501

Michael F. Easley, Governor
Dempsey Benton, Secretary

Tara R. Larson, Acting Director

Certification of Need: Medicaid Inpatient Psychiatric Service under Age 21

Recipient Name: _____ Hospital: _____

Medicaid ID #: _____ Provider #: _____

Date of Birth: _____ Admission Date: _____

Type of Certification: (check 1 item)

☐ Pre-admission/elective

☐ Emergency admission

Medicaid Eligibility Status: (check 1 item)

☐ Medicaid eligible on admission

☐ Pending Medicaid on admission

☐ **No evidence of Medicaid on admission**

☐ Applied for Medicaid during stay

☐ Applied for Medicaid after discharge

At the time of admission, the interdisciplinary team certifies the following:

1. Ambulatory care resources in the community do not meet the treatment needs of the recipient.

2. Proper treatment of the recipient's condition requires services on an inpatient basis under the direction of a physician.

3. The inpatient services can reasonably be expected to improve the recipient's condition or prevent further regression so that services will no longer be needed.

_____	_____	_____
Physician Team Member Signature	Print Name/Title	Date (Mo/Day/Yr)
_____	_____	_____
Other Team Member Signature	Print Name/Title	Date (Mo/Day/Yr)

Submit to: [Insert LME Information Here]

UM004 Rev11032008

Attachment F: Notification of Quality of Care Memo Template

Place LME letterhead here.

To:

From:

Date:

RE: Notification of QOC Complaint Received

We received the following information as a quality of care complaint and are forwarding for your review and follow-up as necessary:

Member Name:	
Member ID:	
Clinical Home Dates of Service:	
Service Provider:	
Service Provider ID:	
Service Provider Level of Care:	
Service Provider Dates of Service:	
Name of complainant:	
Summary of Complaint:	

Please contact me at if you have any further questions regarding this case.

Thank you.

UM006 Rev11122008

Attachment G: Service Authorization Timelines

Service Authorization Timelines, page 1

Authorization Timelines

SERVICE	INITIAL AUTHORIZATION	REQUIRED DOCUMENTS INITIAL	CONCURRENT (REAUTHORIZATION)	REQUIRED DOCUMENTS CONCURRENT
NON-DIRECT ADMIT SERVICES				
Ambulatory Detoxification	• PA required first day of service • Up to 10 day authorization	• RTA • Complete PCP with signatures	• Maximum of 10 days per episode	• New RTA • Updated PCP with signatures if applicable
Day Treatment	• PA required first day of service • Up to 60 day auth	• RTA • Complete PCP with signatures	• Up to 60 days	• New RTA • Updated PCP with signatures • Additional information if applicable
Facility Based Crisis (Professional Tx Services in Facility-Based Crisis Program)	• Pass through of 7 days • PA required before 8th day of service delivered • Up 8 days for initial auth	• RTA • If Crisis admit, only RTA and Service Order required • If planned, complete PCP with signatures	• No additional authorization beyond 15 days per episode	• New RTA • Updated PCP with signatures
Inpatient	• 48 hour pass through for Emergency Admissions after hours • PA required after first 48 hours • Up to 7 day auth	• RTA • CON (if free standing inpatient facility or PRTF • Child only for CON	• Up to 7 days	• New RTA • CON (if was not available at initial request) • Additional information if applicable
Mobile Crisis	• Pass through of 8 hours • PA for next 8 hours required before 9th hour of service delivered	• RTA • Service Order	• PA for final 8 hours required before 17th hour of service delivered • Only a total of 24 hours per episode authorized	• RTA • Service Order
Non-Hospital Medical Detoxification	• PA required first day of service • Up to 10 days auth	• RTA • If Crisis admit, only RTA and Service Order required • If planned, complete PCP with signatures	• Up to 10 days • (service is only allowed 30 total days in a 12 month period)	• New RTA • Updated PCP with signatures • Additional information if applicable
Opioid Treatment	• PA required first day of service • Up to 60 days auth	• RTA • Complete PCP with signatures	• Up to 180 days	• New RTA • Updated PCP with signatures • Additional information if

INST10 & INST11 Rev11032008

Service Authorization Timelines, page 2

Authorization Timelines

SERVICE	INITIAL AUTHORIZATION	REQUIRED DOCUMENTS INITIAL	CONCURRENT (REAUTHORIZATION)	REQUIRED DOCUMENTS CONCURRENT
PH (Partial Hospitalization)	• PA required first day of service • Up to 7 days auth	• RTA • Complete PCP with signatures	• Up to 7 days	• New RTA • Updated PCP with signatures • Additional information if applicable
PSR (Psychosocial Rehabilitation)	• PA required first day of service • Up to 90 days auth	• RTA • Complete PCP with signatures	• Up to 180 days	• New RTA • Updated PCP with signatures • Additional information if applicable
Residential II –IV group type	• PA required first day of service • Up to 30 day auth	• RTA • Complete PCP with signatures	• Up to 90 days	• New RTA • Updated PCP with signatures • Additional information if applicable
Substance Abuse Medically Monitored Community Residential	• PA required first day of service • Up to 10 days auth	• RTA • Complete PCP with signatures	• Up to 10 days • (service is only allowed 30 total days in a 12 month period)	• New RTA • Updated PCP with signatures • Additional information if applicable
Non-medically Monitored Community Residential	• PA required first day of service • Up to 10 days auth	• RTA • Complete PCP with signatures	• Up to 10 days • (service is only allowed 30 total days in a 12 month period)	• New RTA • Updated PCP with signatures • Additional information if applicable
TFC (Therapeutic Foster Care)	• PA required first day of service • Up to 60 day auth	• RTA • Complete PCP with signatures	• Up to 180 days	• New RTA • Updated PCP with signatures • Additional information if applicable

INST10 & INST11 Rev11032008

Service Authorization Timelines, page 3

Authorization Timelines

SERVICE	INITIAL AUTHORIZATION	REQUIRED DOCUMENTS INITIAL	CONCURRENT (REAUTHORIZATION)	REQUIRED DOCUMENTS CONCURRENT
DIRECT ADMIT SERVICES				
ACTT (Assertive Community Treatment Team)	• PA required first day of service • Up to 30 days auth	• RTA • Intro PCP	• Up to 180 days	• New RTA • Complete PCP with signatures • Additional information if applicable
Community Support Individual/Group Child & Adult	• PA required first day of service • Up to 90 days auth	• RTA • Intro PCP	• Up to 90 days	• New RTA • Complete PCP with signatures • Additional information if applicable
CST (Community Support Team)	• PA required first day of service • Up to 30 days auth	• RTA • Intro PCP	• Up to 90 days	• New RTA • Complete PCP with signatures • Additional information if applicable
Intensive In-Home	• PA required first day of service • Up to 30 days auth	• RTA • Intro PCP	• Up to 60 days	• New RTA • Complete PCP with signatures • Additional information if applicable
MST (Multisystemic Therapy)	• PA required first day of service • Up to 30 days auth	• RTA • Intro PCP	• Up to 120 days	• New RTA • Complete PCP with signatures • Additional information if applicable
SAIOP (Substance Abuse Intensive Outpatient Program)	• PA required first day of service • Up to 30 days auth	• RTA • Intro PCP	• Up to 60 days auth	• New RTA • Complete PCP with signatures • Additional information if applicable

INST10 & INST11 Rev11032008

Service Authorization Timelines, page 4

Authorization Timelines

SERVICE	INITIAL AUTHORIZATION	REQUIRED DOCUMENTS INITIAL	CONCURRENT (REAUTHORIZATION)	REQUIRED DOCUMENTS CONCURRENT
SACOT (Substance Abuse Comprehensive Outpatient Treatment)	• PA required first day of service • Up to 60 days auth	• RTA • Intro PCP	• Up to 60 days auth	• New RTA • Complete PCP with signatures • Additional information if applicable
TCM (Targeted Case management) Non _ Waiver	• 8 hour pass through – once in a lifetime • PA required after first 8 hours • Up to 90 days auth	• RTA • Intro PCP	• Up to 90 days	• New RTA • Completed PCP for non-CAP consumer • Additional information if applicable
TCM CAP-MR/DD Waiver Recipients	• 8 hour pass through – once in a lifetime • PA required after first 8 hours • (average of 240 units/year)	• RTA • Intro PCP	• Annual authorization	• New RTA if requesting additional units • Complete PCP with signatures • Additional information if applicable

INST10 & INST11 Rev11032008

Attachment H: Clinical Review Form

Clinical Review Form, page 1

LME

Clinical Review Form

Directions: Complete this form for the clinical review of any behavioral health Medicaid service request. If the review is a potential reduction or denial of services, forward to the Medical Director for routing for review.

Recipient:			
MID #:		**Date of Birth:**	

Requested Service/Units (include CPT & HCPCS codes):	
Reviewer Name:	
Type of Review:	

History (if known): • include health history (incl. chronic illness), • recipient's diagnosis(es) related to the request • onset, course of the disease, recipient's current status	
Medical necessity: describe how the provider believes that the service would correct or ameliorate the recipient's mental illness, improve the problem, prevent it from worsening, compensate for the deficiency, and/or prevent the development of additional health problems	
Is the requested service considered to be **clinically indicated for the diagnosis**? ☐ Yes ☐ No	If No, explain:
Is the requested service considered to be **effective treatment for the consumer's presentation**? ☐ Yes ☐ No	If No, explain:
Is the requested service a **generally recognized accepted method** of practice or treatment? ☐ Yes ☐ No	If No, explain:
Is the requested service the **appropriate level of intensity for the consumer's presentation**? ☐ Yes ☐ No	If No, explain:
What is the expected **duration** of the treatment?	

Clinical Review Form UM007 1 of 2

Clinical Review Form, page 2

Recipient:			
MID #:		**Date of Birth:**	

Additional information:	
Are there **alternative** treatments that could be tried that would be effective and similarly efficacious to the service requested?	If Yes, explain:
☐ Yes ☐ No	

Clinical staff reviewer's recommendation *(choose one from the drop-down list):*	Approve
Reason *(choose one from the list):*	Meets criteria
Comments:	
Staff reviewer signature and credentials:	Date:

LME Medical Director/Psychiatrist/PhD Psychologist Review
Potential Adverse Decision

Directions: Complete, sign, and date this form.

Medical/dental director's recommendation *(circle one):*	Approve	Deny	Reduce	Terminate
	Request additional information			
Reason (select from list to the right) and Comment:	☐ Meets criteria ☐ Not medically necessary ☐ Not covered in §1905(a) of the Social Security Act ☐ Not safe ☐ Not effective ☐ Not generally accepted ☐ Effective alternative treatment available ☐ Insufficient information submitted ☐ Other/see comments			
Medical Director/Psychiatrist/PhD Psychologist signature and credentials:	Date:			

Clinical Review Form UM007 2 of 2

Attachment I: EPSDT Request Clinical Review Form

EPDST Request Clinical Review Form, page 1

LME

EPSDT Request Clinical Review Form

Directions: Complete this form if 1) denying a covered state Medicaid plan service under EPSDT or 2) approving or denying a non-covered state Medicaid plan service for a recipient under 21 years of age. Then forward to the DMA medical or dental director for review. Include evidence-based literature and/or standard of care documentation to support recommendation (if available).

Recipient:			
MID #:		**Date of Birth:**	

Request (include CPT and HCPCS codes):	
Reviewer Name:	
Program:	
Telephone #:	

History (if known): include health history (incl. chronic illness), recipient's diagnosis(es) related to the request (onset, course of the disease, recipient's current status).	
Medical necessity: describe how the requester believes that the service, product, or procedure would correct or ameliorate the recipient's defect, physical or mental illness, or health problem (improve the problem, prevent it from worsening, compensate for the deficiency, and/or prevent the development of additional health problems).	
Is the requested product, service, or procedure considered to be **safe**? ☐ Yes ☐ No	If No, explain:
Is the requested product, service, or procedure considered to be **effective**? ☐ Yes ☐ No	If No, explain:
Is the requested product, service, or procedure **medical in nature**? ☐ Yes ☐ No	If No, explain:
Is the requested product, service, or procedure the **generally recognized accepted method** of practice or treatment? ☐ Yes ☐ No	If No, explain:
Is this request for an **experimental or investigational** treatment? ☐ Yes ☐ No	If Yes, provide name and protocol number:
What is the expected **duration** of the treatment?	
Additional information:	

EPSDT Clinical Review Form
DMA 1060
10/08

EPDST Request Clinical Review Form, page 2

Recipient:			
MID #:		**Date of Birth:**	

Are there **alternative** treatments that could be tried that would be effective and similarly efficacious to the service requested? ☐ Yes ☐ No	If Yes, explain:
(It is not sufficient to cover a standard, lower-cost service instead of the requested service if the lower-cost service is not equally effective in this individual case.)	

Clinical staff reviewer's recommendation *(choose one from the drop-down list):*	Approve
Reason *(choose one from the list):*	Meets criteria
Comments:	
Staff reviewer signature and credentials:	Date:

DMA Medical/Dental Director Review

Directions: Complete, sign, and date this form.

Medical/dental director's recommendation *(circle one):*	Approve	Deny	Reduce	Terminate
	Request additional information			
Reason (select from list to the right) and Comments:	☐ Meets criteria ☐ Not medically necessary ☐ Not covered in §1905(a) of the Social Security Act ☐ Not safe ☐ Not effective ☐ Not medical in nature ☐ Experimental or investigational ☐ Not generally accepted ☐ Effective alternative treatment available ☐ Not rebatable drug (Section 1927 of the SSA) ☐ Insufficient information submitted ☐ Other/see comments			
Medical/dental director signature and credentials:	Date:			

EPSDT Clinical Review Form
DMA 1060
10/08

Attachment J: Service Authorization Notifications

Notice of Approval of Service Request (DMA 3504), page 1

[Insert LME Letterhead]

NOTICE OF APPROVAL OF SERVICE REQUEST

[Insert Date]

[Medical Provider Name]
[Address]

[Recipient Name]
[Recipient Address]
[Recipient MID #]:

Dear [insert name of provider]:

On [insert date] and on behalf of [insert name of recipient], [insert name of physician or other licensed clinician who requested service] requested that Medicaid pay for [insert specific service/procedure requested].

[insert name of service approved, number of units approved, time period of approval, if relevant]

While the request for the above named recipient has been approved, the Medicaid claims payment system will not allow payment of a claim for [insert name of product, procedure, or service] at this time because it is a non-covered [insert product, procedure, or service]. You will be notified concerning when and how the claim should be submitted to receive payment.

Also, please note the following:

1. See the specific clinical coverage policy and Medicaid's Basic Billing Guide for complete details re provision of and payment for services rendered.
   Clinical coverage policies and the Basic Medicaid Billing Guide can be found at http://www.dhhs.state.nc.us/dma/prov.htm.

2. Obtaining prior approval does **not** guarantee payment or ensure recipient eligibility on the date of service. A recipient must be eligible for Medicaid coverage on the date the procedure is performed or the service rendered, and the provider must be an enrolled Medicaid provider for that service and provider type on the day of service.

DMA 3504
01/05/06
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REV. 09/24/08

Notice of Approval of Service Request (DMA 3504), page 2

Recipient Name
MID #

3. Obtaining prior approval does **not** guarantee payment or ensure recipient eligibility on the date of service. A recipient must be eligible for Medicaid coverage on the date the procedure is performed or the service rendered, and the provider must be an enrolled Medicaid provider for that service and provider type on the day of service.

4. **The service must be rendered as specified in this notice,** including service approved, number of units approved, time period of approval, if relevant. See previous page re details of authorization.

5. Effective the date of this notice and if the prior approval is time limited, this EPSDT prior approval authorization is time limited to the first of the following to occur:

    a. time limit specified by this prior approval **OR**
    b. 365 days from date of this prior approval.

6. You have up to 365 days from the date the service is rendered to submit the claim for payment. See specific clinical coverage policy and the Basic Medicaid Billing Guide for complete details re provision of and payment for services rendered.

If you have questions concerning this notice of approval, please contact [insert name of contact person] at [insert telephone number]. Thank you for serving the citizens of North Carolina by participating in the Medicaid program.

Sincerely,

[insert contact name and credentials]
[insert telephone # of contact]

C: Recipient

DMA 3504
01/05/06
REV. 03/02/07
REV. 09/24/08

2

Notice of Approval of Service Request (EPSDT) (DMA 3504E), page 1

[Insert LME Letterhead]

NOTICE OF APPROVAL OF SERVICE REQUEST

[Insert Date]

[Medical Provider Name]
[Address]

[Recipient Name]
[Recipient Address]
[Recipient MID #]:

Dear [insert name of provider]:

On [insert date] and on behalf of [insert name of recipient], [insert name of physician or other licensed clinician who requested service] requested that Medicaid pay for [insert specific service/procedure requested]. Effective [insert date], Medicaid approved this request under Early and Periodic Screening, Diagnostic, and Testing (EPSDT) as specified below.

[insert name of service approved, number of units approved, time period of approval, if relevant]

EPSDT makes services available to recipients under 21 years of age without many of the restrictions Medicaid imposes for services under a waiver **OR** for adults (recipients over 21 years of age). Specifically, the service limitations on scope, amount, duration, frequency, and other specific criteria described in DMA's clinical coverage policies may be exceeded or may not apply provided documentation shows that the requested service is medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]. The services must be prescribed by the recipient's physician, therapist, or other licensed practitioner.

While the request for the above named recipient has been approved, the Medicaid claims payment system will not allow payment of a claim for [insert name of product, procedure, or service] at this time because it is a non-covered [insert product, procedure, or service]. You will be notified concerning when and how the claim should be submitted to receive payment.

Also, please note the following:

1. **This notice of approval is valid only as long as the recipient is under 21 years of age. If the recipient is over 21 years of age and you have not provided the service, although prior approval was granted, please follow DMA's published procedures and submit a new request for prior approval, if prior approval is required.** See the specific clinical coverage policy and Medicaid's Basic Billing Guide for complete details re provision of and payment for services rendered.
   Clinical coverage policies and the Basic Medicaid Billing Guide can be found at http://www.dhhs.state.nc.us/dma/prov.htm.

DMA 3504
01/05/06
REV. 09/09/06

Notice of Approval of Service Request (EPSDT) (DMA 3504E), page 2

Recipient Name
MID #

2. Obtaining prior approval does **not** guarantee payment or ensure recipient eligibility on the date of service. A recipient must be eligible for Medicaid coverage on the date the procedure is performed or the service rendered, and the provider must be an enrolled Medicaid provider for that service and provider type on the day of service.

3. **The service must be rendered as specified in this notice,** including service approved, number of units approved, time period of approval, if relevant. See previous page re details of authorization.

4. Effective the date of this notice and if the prior approval is time limited, this EPSDT prior approval authorization is time limited to the first of the following to occur:

    a. recipient reaches 21 years of age **OR**
    b. time limit specified by this prior approval **OR**
    c. 365 days from date of this prior approval.

5. If the recipient is under 21 years of age and the authorization has expired and if the service, product, or procedure is still desired and is medically necessary to correct or ameliorate a defect, physical and mental illness, or a condition identified by screening, submit a new request for prior approval. See specific clinical coverage policy and the Basic Medicaid Billing Guide for complete details re provision of and payment for services rendered.

6. You have up to 365 days from the date the service is rendered to submit the claim for payment. See specific clinical coverage policy and the Basic Medicaid Billing Guide for complete details re provision of and payment for services rendered.

If you have questions concerning this notice of approval, please contact [insert name of contact person] at [insert telephone number]. Thank you for serving the citizens of North Carolina by participating in the Medicaid program.

Sincerely,

[insert contact name and credentials]
[insert telephone # of contact]

C: Recipient

DMA 3504
01/05/06
REV. 09/09/06
REV. 03/02/07

2

Notice of Prior Approval When Requested Time Period for Approval Exceeds Policy Maximum (DMA 1059)

[Insert LME Letterhead]

NOTICE OF PRIOR APPROVAL WHEN REQUESTED TIME PERIOD FOR APPROVAL EXCEEDS POLICY MAXIMUM

[insert date notice to be mailed]

Provider Name
Provider Address

Recipient's or Legal Rep's Name
Address

RE: [insert recipient's name]
MID: [insert MID #]

Dear Provider:

Your request for [insert service, product, procedure, or description] on behalf of [insert the recipient name] has been approved. Please note that prior approval for this [insert service, product, or procedure or description] has been given for the maximum time allowable according to the Division of Medical Assistant's clinical coverage policy on [insert name of clinical coverage policy], [insert number of clinical coverage policy]. For this [insert service, product, or procedure], the approved time period is from [insert start date] to [insert end date].

If you have questions, please contact me at the number below.

Sincerely,

[insert Name and credentials Title]
[insert Telephone #]

DMA 1059
11/22/06
REV. 09/24/08

Notice of Decision on Initial Request for Medicaid Services (DMA 2001), page 1

[Insert LME Letterhead]

NOTICE OF DECISION ON INITIAL REQUEST FOR MEDICAID SERVICES

[Insert date to be mailed]

Recipient's or Legal Rep's name
Address

Provider Name
Provider Address

RE: [insert recipient name]
MID: [insert MID #]

Dear [insert name of recipient or parent/legal representative/authorized representative]:

The above named provider requested prior approval for [insert specific service/procedure, # of units and time period, if relevant]. After reviewing the documentation submitted by the provider, Medicaid [insert **denied, reduced, or changed]** the request effective the **date this notice was mailed**. [If approving any other Medicaid service not requested by the provider or changes in the service request submitted by the provider, insert: Medicaid **approved** (insert: service/procedure, # of units and time period, if relevant) effective the **date this notice was mailed**. May insert other effective date as needed]. This letter explains why the decision was made and tells you how to appeal if you disagree.

It is also important to note that you **may** also be eligible for other Medicaid services. Please check with your physician, other licensed clinician, or provider to determine if [if recommending no services, insert: there are other services that are more appropriate for you or if recommending services, insert: the services listed below are appropriate for you].

- List Medicaid services.
- List Medicaid services.

Medicaid [insert denied, reduced, changed] the request because [insert specific reason]. The decision is based on the authority granted to the North Carolina Department of Health and Human Services and its contractors by the Code of Federal Regulations,

Si desea apelar esta decisión, debe responder a no más tardar de 30 días a partir de la fecha que esta carta fue enviada. Si necesitas ayuda para leer y entender la carta, por favor contáctese con el 1-800-662-7030. DIGA AL OPERADOR QUE LA NOTIFICACION DMA 2001.

DMA 2001
09/08/05
REV 09/24/08

Notice of Decision on Initial Request for Medicaid Services (DMA 2001), page 2

Chapter 42 Part 431, Subpart E, N.C.G.S. §108A-25(b) and §108A-54, as well as the law(s) and policy(ies) specified below.

- [insert NCAC citation, C.F.R., or other applicable law or title of specific medical policy supporting decision]
- United States Code [insert code]
- North Carolina Administrative Code [insert code]
- North Carolina Administrative Code 10A NCAC 22O .0301

Medicaid's clinical coverage policies can be found at http://www.ncdhhs.gov/dma/mp/mpindex.htm.

YOU HAVE THE RIGHT TO APPEAL THIS DECISION. If you decide to appeal the decision, you must file for an evidentiary hearing with the Office of Administrative Hearings. **YOU HAVE 30 DAYS FROM THE DATE THIS DECISION LETTER WAS MAILED TO FILE THE REQUEST FOR HEARING.**

To learn more about the hearing process or to speak with a Medicaid clinical policy analyst about this decision, call the Appeals Coordinator, Division of Medical Assistance at 919-855-4260. You may also call the toll free **CARE-LINE, Information and Referral Services, at 1-800-662-7030** and request that your call be transferred. The enclosed general information sheet also explains the hearing process.

THE HEARING PROCESS AND FILING THE REQUEST:

- Hearings are conducted by an administrative law judge with the Office of Administrative Hearings (OAH).
- To file for a hearing, you must submit **a completed hearing request form** (enclosed in this mailing). You can also obtain a hearing request form by calling the Division of Medical Assistance at the number specified above, or you can call the Office of Administrative Hearings at 919-431-3000.
- Mail or fax the completed hearing request form to Clerk, Office of Administrative Hearings **AND** General Counsel, North Carolina Department of Health and Human Services at the addresses or fax numbers on the enclosed hearing request form. **The completed form must be filed within 30 days of the date this decision letter was mailed**. As the mailing date is located on the envelope, **please keep the envelope containing this decision letter**.
- The Office of Administrative Hearings or the Mediation Network of North Carolina will contact you to discuss your case and to offer an opportunity for mediation in an effort to resolve your appeal. If mediation resolves your case, your hearing will be dismissed, and services will be provided as specified by the Mediation Network of North Carolina.
- If you do not accept the offer of mediation or the results of mediation, your case will proceed to hearing. You will be notified by mail of the date, time, and location of your hearing.

Recipient Name [insert]
MID # [insert]

DMA 2001
09/08/05
REV 09/24/08

Notice of Decision on Initial Request for Medicaid Services (DMA 2001), page 3

- The administrative law judge will make a decision and will send that decision to Medicaid for a final agency decision. You will receive a written copy of both the administrative law judge's decision and Medicaid's final agency decision.
- If you do not agree with Medicaid's final agency decision, you may ask for a judicial review in superior court.
- You may represent yourself in the appeal process, hire an attorney, or ask a relative, friend, or other spokesperson to speak for you.

Free legal aid may be available to assist with your appeal. Contact your nearest Legal Aid of North Carolina office or call 919-856-2564 or toll-free at 1-866-369-6923 to obtain the telephone number of the office that serves your community.

Sincerely,

[insert contact name and credentials]
[insert telephone # of contact]

Enclosure: Recipient Hearing Request Form, DMA 2003
(Only the recipient may appeal the decision).

C: Provider
Appeals Coordinator, Division of Medical Assistance
Office of Administrative Hearings

3

Recipient Name [insert]
MID # [insert]

DMA 2001
09/08/05
REV 09/24/08

Notice of Decision on Initial Request for Medicaid Services (DMA 2001), page 4

POSSIBLE EXAMPLES FOR PARAGRAPH #1 SUGGESTED BY VO DO NOT INCLUDE WITH NOTICE

While the scenarios are written for behavioral health services, they should work for services that have similar request patterns. They should also work for services that have no time frames or units by deleting them from the samples. These scenarios in their entirety would be substituted for paragraph #1, page 1.

Initial Request – Denial – Community Support Services: Request for 416 units of Community Support from 10/1/08 – 12/30/08. Peer Advisor decision is a straight denial. Letter date is 9/25/08. Suggested paragraph:

The above named provider requested prior authorization for 416 units of Community Support Services from October 1, 2008 – December 30, 2008. After reviewing the documentation submitted by the provider, Medicaid **denied** the request **effective the date this notice was mailed**.

Initial Request – Reduction – Community Support Services: Request for 416 units of Community Support from 10/1/08 – 12/30/08. Peer Advisor decision is a partial authorization, a reduction. Letter date is 9/25/08. Suggested paragraph:

The above named provider requested prior authorization for 416 units of Community Support Services from October 1, 2008 – December 30, 2008. After reviewing the documentation submitted by the provider, Medicaid **reduced** the request effective the **date this notice was mailed**. Medicaid has authorized 200 units for the period October 1, 2008 – December 30, 2008.

Initial Request – Denial - Residential: Request for 60 days of Residential from 10/1/08 - 11/29/08. Peer Advisor decision is a straight denial. Letter date is 9/25/08. Suggested paragraph:

The above named provider requested prior authorization for 60 days of Residential Services from October 1, 2008 – November 29, 2008. After reviewing the documentation submitted by the provider, Medicaid **denied** the request effective the **date this notice was mailed**.

Initial Request – Reduction Residential: Request for 60 days of Residential from 10/1/08 – 11/29/08. Peer Advisor decision is a partial authorization, a reduction. Letter date is 9/25/08. Suggested paragraph:

Notice of Decision on Initial Request for Medicaid Services (DMA 2001), page 5

The above named provider requested prior authorization for 60 days of Residential Services from October 1, 2008 – November 29, 2008. After reviewing the documentation submitted by the provider, Medicaid **reduced** the request effective the **date this notice was mailed**. Medicaid has authorized 30 days for the period October 1, 2008 – October 30, 2008.

Initial Request – Changed (Different service approved than requested): Request for 416 units (8 hrs/wk or 32 units) of Community Support Services from 10/1/08 – 12/30/08. Decision is to authorize Community Support Team at 140 units per week (35 hours) for the period requested. Letter date is 09/1/08. Suggested paragraph:

The above named provider requested prior approval for [insert name of service] from [insert period—October 01–November 29, 2008-if applicable]. After reviewing the documentation submitted by the provider, Medicaid **changed** this request. Medicaid **approved** [insert: service/procedure, # of units and time period, if relevant] effective the **date this notice was mailed**. May insert other effective date as needed].

5

Recipient Name [insert]
MID # [insert]

DMA 2001
09/08/05
REV 09/24/08

Notice of Decision on Initial Request for Medicaid Services (EPSDT) (DMA 2001E), page 1

[Insert LME Letterhead]

NOTICE OF DECISION ON INITIAL REQUEST FOR MEDICAID SERVICES

[insert date notice to be mailed]

Recipient's or Legal Rep's name
Address

Provider Name
Provider Address

RE: [insert recipient name]
MID: [insert MID #]

Dear [insert name of recipient or parent/legal representative/authorized representative]:

The above named provider requested prior approval for [insert specific service/procedure, # of units and time period, if relevant]. After reviewing the documentation submitted by the provider, Medicaid [insert **denied, reduced, or changed]** the request effective the **date this notice was mailed**. [If approving any other Medicaid service not requested by the provider or changes in the service request submitted by the provider, insert: Medicaid **approved** (insert: service/procedure, # of units and time period, if relevant) effective the **date this notice was mailed**. May insert other effective date as needed]. This letter explains why the decision was made and tells you how to appeal if you disagree.

It is also important to note that you **may** also be eligible for other Medicaid services. Please check with your physician, other licensed clinician, or provider to determine if [if recommending no services, insert: there are other services that are more appropriate for you or if recommending services, insert: the services listed below are appropriate for you].

- List Medicaid services
- List Medicaid services

As the recipient is under 21 years of age, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) apply. EPSDT makes services available to recipients under 21 years of age without many of the restrictions Medicaid imposes for services under a waiver **OR** for adults (recipients over 21 years of age). Specifically, the service limitations on scope, amount, duration, frequency, and other specific criteria described in DMA's clinical

Si desea apelar esta decisión, debe responder a no más tardar de 30 días a partir de la fecha que esta carta fue enviada. Si necesitas ayuda para leer y entender la carta, por favor contáctese con el 1-800-662-7030. DIGA AL OPERADOR QUE LA NOTIFICACION DMA 2001E.

DMA 2001E
09/08/05
REV 09/24/08

Notice of Decision on Initial Request for Medicaid Services (EPSDT) (DMA 2001E), page 2

coverage policies may be exceeded or may not apply if documentation submitted by the provider shows that all EPSDT criteria are met. The services must be prescribed by the recipient's physician, therapist, or other licensed practitioner.

When a recipient is under 21 years of age, the provider's request for service is evaluated under the applicable Medicaid clinical coverage policies as well as the EPSDT criteria. If the request cannot be approved under the clinical coverage policy criteria, all of the EPSDT criteria must be met to approve the request.

Based on the information submitted by the provider, the recipient does not meet [insert specific policy criteria not met]. As the recipient is under 21 years of age, the request was also evaluated under the EPSDT criteria. Medicaid denied this request because the [insert: for single criterion not met, insert: criterion specified below was or for several criteria not met, insert: criteria specified below were] not met.

- EPSDT services must be coverable services within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act].
- The service must be medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] diagnosed by the recipient's physician, therapist, or other licensed practitioner.
- The requested service must be determined to be medical in nature.
- The service must be safe.
- The service must be effective.
- The service must be generally recognized as an accepted method of medical practice or treatment.
- The service must not be experimental/investigational.

The decision is based on the authority granted to the North Carolina Department of Health and Human Services and its contractors by the Code of Federal Regulations, Chapter 42 Part 431, Subpart E, N.C.G.S. §108A-25(b) and §108A-54, as well as the law(s) and policy(ies) specified below.

- [insert NCAC citation, C.F.R., or other applicable law or title of specific medical policy supporting decision]
- United States Code [insert code]
- United States Code 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]
- North Carolina Administrative Code [insert code]
- North Carolina Administrative Code 10A NCAC 22O .0301

Medicaid's clinical coverage policies and EPSDT policy can be found at the websites listed below.

http://www.ncdhhs.gov/dma/mp/mpindex.htm
http://www.ncdhhs.gov/dma/EPSDTprovider.htm

Notice of Decision on Initial Request for Medicaid Services (EPSDT) (DMA 2001E), page 3

YOU HAVE THE RIGHT TO APPEAL THIS DECISION. If you decide to appeal the decision, you must file for an evidentiary hearing with the Office of Administrative Hearings. **YOU HAVE 30 DAYS FROM THE DATE THIS DECISION LETTER WAS MAILED TO FILE THE APPEAL REQUEST.**

To learn more about the hearing process or to speak with a Medicaid clinical policy analyst about this decision, call the Appeals Coordinator, Division of Medical Assistance at 919-855-4260. You may also call the toll free **CARE-LINE, Information and Referral Services, at 1-800-662-7030** and request that your call be transferred. The enclosed general information sheet also explains the hearing process.

THE HEARING PROCESS AND FILING THE REQUEST:

- Hearings are conducted by an administrative law judge with the Office of Administrative Hearings (OAH).
- To file for a hearing, you must submit **a completed hearing request form** (enclosed in this mailing). You can also obtain a hearing request form by calling the Division of Medical Assistance at the number specified above, or you can call the Office of Administrative Hearings at 919-431-3000.
- Mail or fax the completed request form to Clerk, Office of Administrative Hearings **AND** General Counsel, North Carolina Department of Health and Human Services at the addresses or fax numbers on the enclosed hearing request form. **The completed form must be filed within 30 days of the date this decision letter was mailed**. As the mailing date is located on the envelope, **please keep the envelope containing this decision letter**.
- The Office of Administrative Hearings or the Mediation Network of North Carolina will contact you to discuss your case and to offer an opportunity for mediation in an effort to resolve your appeal. If mediation resolves your case, your hearing will be dismissed, and services will be provided as specified by the Mediation Network of North Carolina.
- If you do not accept the offer of mediation or the results of mediation, your case will proceed to hearing. You will be notified by mail of the date, time, and location of your hearing.
- The administrative law judge will make a decision and will send that decision to Medicaid for a final agency decision. You will receive a written copy of both the administrative law judge's decision and Medicaid's final agency decision.
- If you do not agree with Medicaid's final agency decision, you may ask for a judicial review in superior court.
- You may represent yourself in the hearing process, hire an attorney, or ask a relative, friend, or other spokesperson to speak for you.

Free legal aid may be available to assist with your appeal. Contact your nearest Legal Aid of North Carolina office or call 919-856-2564 or toll-free at 1-866-369-6923 to obtain the telephone number of the office that serves your community.

Sincerely,

3

Recipient Name [insert]
MID # [insert]

DMA 2001E
09/08/05
REV 09/24/08

Notice of Decision on Initial Request for Medicaid Services (EPSDT) (DMA 2001E), page 4

[insert contact name and credentials]
[insert telephone # of contact]

Enclosure: Recipient Hearing Request Form, DMA 2003
(Only the recipient may appeal the decision).

C: Provider
Appeals Coordinator, Division of Medical Assistance
Office of Administrative Hearings

Recipient Name [insert]
MID # [insert]

DMA 2001E
09/08/05
REV 09/24/08

Notice of Decision on Initial Request for Medicaid Services (EPSDT) (DMA 2001E), page 5

POSSIBLE EXAMPLES FOR PARAGRAPH #1 SUGGESTED BY VO DO NOT INCLUDE WITH NOTICE

While the scenarios are written for behavioral health services, they should work for services that have similar request patterns. They should also work for services that have no time frames or units by deleting them from the samples. These scenarios in their entirety would be substituted for paragraph #1, page 1.

Initial Request – Denial – Community Support Services: Request for 416 units of Community Support from 10/1/08 – 12/30/08. Peer Advisor decision is a straight denial. Letter date is 9/25/08. Suggested paragraph:

The above named provider requested prior authorization for 416 units of Community Support Services from October 1, 2008 – December 30, 2008. After reviewing the documentation submitted by the provider, Medicaid **denied** the request **effective the date this notice was mailed**.

Initial Request – Reduction – Community Support Services: Request for 416 units of Community Support from 10/1/08 – 12/30/08. Peer Advisor decision is a partial authorization, a reduction. Letter date is 9/25/08. Suggested paragraph:

The above named provider requested prior authorization for 416 units of Community Support Services from October 1, 2008 – December 30, 2008. After reviewing the documentation submitted by the provider, Medicaid **reduced** the request effective the **date this notice was mailed**. Medicaid has authorized 200 units for the period October 1, 2008 – December 30, 2008.

Initial Request – Denial - Residential: Request for 60 days of Residential from 10/1/08 - 11/29/08. Peer Advisor decision is a straight denial. Letter date is 9/25/08. Suggested paragraph:

The above named provider requested prior authorization for 60 days of Residential Services from October 1, 2008 – November 29, 2008. After reviewing the documentation submitted by the provider, Medicaid **denied** the request effective the **date this notice was mailed**.

Initial Request – Reduction Residential: Request for 60 days of Residential from 10/1/08 – 11/29/08. Peer Advisor decision is a partial authorization, a reduction. Letter date is 9/25/08. Suggested paragraph:

Notice of Decision on Initial Request for Medicaid Services (EPSDT) (DMA 2001E), page 6

The above named provider requested prior authorization for 60 days of Residential Services from October 1, 2008 – November 29, 2008. After reviewing the documentation submitted by the provider, Medicaid **reduced** the request effective the **date this notice was mailed**. Medicaid has authorized 30 days for the period October 1, 2008 – October 30, 2008.

Initial Request – Changed (Different service approved than requested): Request for 416 units (8 hrs/wk or 32 units) of Community Support Services from 10/1/08 – 12/30/08. Decision is to authorize Community Support Team at 140 units per week (35 hours) for the period requested. Letter date is 09/1/08. Suggested paragraph:

The above named provider requested prior approval for [insert name of service] from [insert period—October 01–November 29, 2008-if applicable]. After reviewing the documentation submitted by the provider, Medicaid **changed** this request. Medicaid **approved** [insert: service/procedure, # of units and time period, if relevant] effective the **date this notice was mailed**. May insert other effective date as needed].

6

Recipient Name [insert]
MID # [insert]

DMA 2001E
09/08/05
REV 09/24/08

Notice of Decision on a Continuing Request for Medicaid Services (DMA 2002), page 1

[Insert LME Letterhead]

NOTICE OF DECISION ON A CONTINUING REQUEST FOR MEDICAID SERVICES

[insert date to be mailed]

Recipient's or Legal Rep's name
Address

Provider Name
Provider Address

RE: [insert recipient name]
MID: [insert MID #]

Dear [insert name of recipient or parent/legal representative/authorized representative]:

The above named provider requested prior approval for (<> units of <service/level of care> for the period <date> through <date> (ex. October 01-30, 2008 or November 01, 2008-January 01, 2009). Insert either option 1 or 2 here].

Option 1—Reduction or Change in Service Request Submitted by the Provider
After reviewing the documentation submitted by the provider, Medicaid could not approve the request for the above named recipient. Medicaid **approved** (insert: (<> units of <service/level of care> for the period <date> through <date> (ex. October 01-30, 2008 or November 01, 2008-January 01, 2009). This decision is a [insert: **reduction** of or **change** in] the prior authorization request submitted by your provider, and it is effective **30 days from the date this notice was mailed**.

Option 2—Termination of Requested Service
After reviewing the documentation submitted by the provider, Medicaid could not approve the request for the above named recipient. This decision **terminates** [insert name of service/level of care] effective **30 days from the date this notice was mailed**.

This letter explains why the decision was made and tells you how to appeal if you disagree. It is also important to note that you **may** also be eligible for other Medicaid services. Please check with your physician, other licensed clinician, or provider to determine if [if recommending no services, insert: there are other services that are more appropriate for you or if recommending services, insert: the services listed below are appropriate for you].

- List Medicaid services.

Si desea apelar esta decisión, debe responder a no más tardar de 30 días a partir de la fecha que esta carta fue enviada. Si necesitas ayuda para leer y entender la carta, por favor contáctese con el 1-800-662-7030. DIGA AL OPERADOR QUE LA NOTIFICACION DMA 2002.

DMA 2002
09/08/05
REV 09/24/08

Notice of Decision on a Continuing Request for Medicaid Services (DMA 2002), page 2

- List Medicaid services.

Medicaid [insert terminated, reduced, or changed] the request because [insert specific reason].

The decision is based on the authority granted to the North Carolina Department of Health and Human Services and its contractors by the Code of Federal Regulations, Chapter 42 Part 431, Subpart E, N.C.G.S. §108A-25(b) and §108A-54, as well as the law(s) and policy(ies) specified below.

- [insert NCAC citation, C.F.R., or other applicable law or title of specific medical policy supporting decision]
- United States Code [insert code]
- North Carolina Administrative Code [insert code]
- North Carolina Administrative Code 10A NCAC 22O .0301

Medicaid's clinical coverage policies can be found on its website at http://www.ncdhhs.gov/dma/mp/mpindex.htm.

YOU HAVE THE RIGHT TO APPEAL THIS DECISION. If you decide to appeal the decision, you must file for an evidentiary hearing with the Office of Administrative Hearings. **YOU HAVE 30 DAYS FROM THE DATE THIS DECISION LETTER WAS MAILED TO FILE THE REQUEST FOR HEARING.**

To learn more about the hearing process or to speak with a Medicaid clinical policy analyst about this decision, call the Appeals Unit, Division of Medical Assistance at 919-855-4260. You may also call the toll free **CARE-LINE, Information and Referral Services, at 1-800-662-7030** and request that your call be transferred. The enclosed general information sheet also explains the hearing process.

THE HEARING PROCESS AND FILING THE REQUEST:

- Hearings are conducted by an administrative law judge with the Office of Administrative Hearings (OAH).
- To file for a hearing, you must submit **a completed hearing request form** (enclosed in this mailing). You can also obtain a hearing request form by calling the Division of Medical Assistance at the number specified above, or you can call the Office of Administrative Hearings at 919-431-3000.
- Mail or fax the completed hearing request form to Clerk, Office of Administrative Hearings **AND** General Counsel, North Carolina Department of Health and Human Services at the addresses or fax numbers on the enclosed hearing request form. **The completed form must be filed within 30 days of the date this decision letter was mailed**. As the mailing date is located on the envelope, **please keep the envelope containing this decision letter**.

Recipient Name [insert]
MID # [insert]

DMA 2002
09/08/05
REV 09/24/08

Notice of Decision on a Continuing Request for Medicaid Services (DMA 2002), page 3

- The Office of Administrative Hearings or the Mediation Network of North Carolina will contact you to discuss your case and to offer an opportunity for mediation in an effort to resolve your appeal. If mediation resolves your case, your hearing will be dismissed, and services will be provided as specified by the Mediation Network of North Carolina.
- If you do not accept the offer of mediation or the results of mediation, your case will proceed to hearing. You will be notified by mail of the date, time, and location of your hearing.
- The administrative law judge will make a decision and will send that decision to Medicaid for a final agency decision. You will receive a written copy of both the administrative law judge's decision and Medicaid's final agency decision.
- If you do not agree with Medicaid's final agency decision, you may ask for a judicial review in superior court.
- You may represent yourself in the hearing process, hire an attorney, or ask a relative, friend, or other spokesperson to speak for you.
- If a **continuing** request for services is denied and you submit a request for hearing within **30 days of the date this decision letter was mailed and** as long as you remain otherwise Medicaid eligible, unless you give up this right, you are entitled to receive services during the pendency of the appeal. **This right to receive services applies even if you change providers.** Services will be provided at the same level you were receiving the day before the decision or the level requested by your provider, whichever is less. The services that continue must be based on your current condition and must be provided in accordance with all applicable state and federal statutes and rules and regulations.
- If you lose your appeal, you may be required to pay for the services that continue because of the appeal.

Free legal aid may be available to assist with your appeal. Contact your nearest Legal Aid of North Carolina office or call 919-856-2564 or toll-free at 1-866-369-6923 to obtain the telephone number of the office that serves your community.

Sincerely,

[insert contact name and credentials]
[insert telephone # of contact]

Enclosure: Recipient Hearing Request Form, DMA 2003
(Only the recipient may appeal the decision).

C: Provider
Office of Administrative Hearings
Appeals Unit, Division of Medical Assistance

3

Recipient Name [insert]
MID # [insert]

DMA 2002
09/08/05
REV 09/24/08

Notice of Decision on a Continuing Request for Medicaid Services (DMA 2002), page 4

POSSIBLE PARAGRAPH 1 SAMPLES

DO NOT INCLUDE WITH NOTICE

Example #1: The above named provider requested prior authorization for Community Support Services at an intensity of 416 units for a 90 day period. After reviewing the request, Medicaid **reduced** the request effective **30 days from the date this notice was mailed**. Two hundred units are authorized for the period October 15-November 25, 2008 or October 15, 2007-January 14, 2009.

Example #2: The above named provider requested prior authorization for Community Support Services at an intensity of 416 units for a 90 day period. After reviewing the request, Medicaid **changed** the request. Community Support Team is authorized at 1,820 units for the period October 01-December 29, 2008. The decision is effective **30 days from the date this notice was mailed**.

Example #3: The above named provider requested prior authorization for skilled level of care. After reviewing the request, Medicaid **reduced** the request to intermediate level of care effective **30 days from the date this notice was mailed**.

Example #4: The above named provider requested prior authorization for physical therapy at an intensity of 45 units for a 60 day period. After reviewing the request, Medicaid **terminated** the service effective **30 days from the date this notice was mailed**.

POSSIBLE EXAMPLES FOR PARAGRAPH #1 SUGGESTED BY VO

While the scenarios are written for behavioral health services, they should work for services that have similar request patterns. They should also work for services that have no time frames or units by deleting them from the samples. These scenarios in their entirety would be substituted for paragraph #1, page 1.

Concurrent Request – Reduction – Community Support: Request for 416 units (8 hrs/wk) of Community Support from 10/1/08 – 12/30/08. Peer Advisor decision is to authorize 4 hrs/wk. Letter date is 10/1/08. Total authorized units accommodate 8 hrs/wk for 30 days from letter date, and then 4 hrs/week for the remainder of the authorization period. Suggested paragraph:

4

Recipient Name [insert]
MID # [insert]

DMA 2002
09/08/05
REV 09/24/08

Notice of Decision on a Continuing Request for Medicaid Services (DMA 2002), page 5

The above named provider requested prior authorization for 416 units of Community Support Services from October 1, 2008 – December 30, 2008. After reviewing the documentation submitted by the provider, Medicaid **reduced** this request. Medicaid has authorized 277 units for the period October 1, 2008 – December 30, 2008. **This authorization includes units at the lesser of the previous or requested rate for the first 30 days, with the reduction applied to the remaining days of the authorization period.** The decision is effective **30 days from the date this notice was mailed**.

Concurrent Request – Reduction - Residential: Request for 60 days of Residential services from 10/1/08 – 11/29/08. Peer Advisor decision is to deny ongoing Residential services. Letter date is 10/1/08.

The above named provider requested prior authorization for 60 days of Residential Services from October 1, 2008 – November 29, 2008. After reviewing the documentation submitted by the provider, Medicaid **reduced** this request. Medicaid has authorized 30 days for the period October 1, 2008 – October 30, 2008. The decision is effective **30 days from the date this notice was mailed**.

Concurrent/Continuing Request – Changed (Different service approved than requested)

Request for 416 units (8 hrs/wk or 32 units) of Community Support from 10/1/08 – 12/30/08. Decision is to authorize Community Support Team at 140 units per week (35 hours) for the period requested. Letter date is 09/1/08. Suggested paragraph:

The above named provider requested prior approval for [insert name of service] from [insert period—October 01–November 29, 2008-if applicable]. After reviewing the documentation submitted by the provider, Medicaid **changed** this request. Medicaid **approved** [insert: service/procedure, # of units and time period, if relevant] effective **30 days from the date this notice was mailed**.

Concurrent/Continuing Request - Terminated

Request for 416 units of Community Support Services is requested from 10/1/08 – 12/30/08. Decision is a straight termination. Letter date is 09/01/08. Suggested paragraph:

The above named provider requested prior approval for [insert #] units of [insert name of service] from [insert time period—i.e., October 1-December 30, 2008 or November 01, 2008-January 01, 2009]. After reviewing the documentation submitted by the provider, Medicaid **terminated** the service. The decision is effective **30 days from the date this notice was mailed**.

Notice of Decision on a Continuing Request for Medicaid Services (EPSDT) (DMA 2002E), page 1

[Insert LME Letterhead]

NOTICE OF DECISION ON A CONTINUING REQUEST FOR MEDICAID SERVICES

[insert date notice to be mailed]

Recipient's or Legal Rep's name
Address

Provider Name
Provider Address

RE: [insert recipient name]
MID: [insert MID #]

Dear [insert name of recipient or parent/legal representative/authorized representative]:

The above named provider requested prior approval for (<> units of <service/level of care> for the period <date> through <date> (ex. October 01-30, 2008 or November 01, 2008-January 01, 2009). Insert either option 1 or 2 here.]

Option 1—Reduction or Change in Service Request Submitted by the Provider
After reviewing the documentation submitted by the provider, Medicaid could not approve the request. Medicaid **approved** (insert: (<> units of <service/level of care> for the period <date> through <date> (ex. October 01-30, 2008 or November 01, 2008-January 01, 2009). The decision is a [insert: **reduction** of or **change** in] the prior authorization request submitted by your provider, and it is effective **30 days from the date this notice was mailed**.

Option 2—Termination of Requested Service
After reviewing the documentation submitted by the provider, Medicaid could not approve the request. The decision **terminates** [insert name of service/level of care] effective **30 days from the date this notice was mailed**.

This letter explains why the decision was made and tells you how to appeal if you disagree. It is also important to note that you **may** also be eligible for other Medicaid services. Please check with your physician, other licensed clinician, or provider to determine if [if recommending no services, insert: there are other services that are more appropriate for you or if recommending services, insert: the services listed below are appropriate for you].

Si desea apelar esta decisión, debe responder a no más tardar de 30 días a partir de la fecha que esta carta fue enviada. Si necesitas ayuda para leer y entender la carta, por favor contáctese con el 1-800-662-7030. DIGA AL OPERADOR QUE LA NOTIFICACION DMA 2002E.

DMA 2002E
09/08/05
REV 09/24/08

Notice of Decision on a Continuing Request for Medicaid Services (EPSDT) (DMA 2002E), page 2

- List Medicaid services
- List Medicaid services

As the recipient is under 21 years of age, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) apply. EPSDT makes services available to recipients under 21 years of age without many of the restrictions Medicaid imposes for services under a waiver **OR** for adults (recipients over 21 years of age). Specifically, the service limitations on scope, amount, duration, frequency, and other specific criteria described in DMA's clinical coverage policies may be exceeded or may not apply if documentation submitted by the provider shows that all EPSDT criteria are met. The services must be prescribed by the recipient's physician, therapist, or other licensed practitioner.

When a recipient is under 21 years of age, the provider's request for service is evaluated under the applicable Medicaid clinical coverage policies as well as the EPSDT criteria. If the request cannot be approved under the clinical coverage policy criteria, all of the EPSDT criteria must be met to approve the request.

Based on the information submitted by the provider, the recipient does not meet [insert specific policy criteria not met]. As the recipient is under 21 years of age, the request was also evaluated under the EPSDT criteria. Medicaid denied this request because the [insert: for single criterion not met, insert: criterion specified below was or for several criteria not met, insert: criteria specified below were] not met.

- EPSDT services must be coverable services within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act].
- The service must be medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] diagnosed by the recipient's physician, therapist, or other licensed practitioner.
- The requested service must be determined to be medical in nature.
- The service must be safe.
- The service must be effective.
- The service must be generally recognized as an accepted method of medical practice or treatment.
- The service must not be experimental/investigational.

The decision is based on the authority granted to the North Carolina Department of Health and Human Services and its contractors by the Code of Federal Regulations, Chapter 42 Part 431, Subpart E, N.C.G.S. §108A-25(b) and §108A-54, as well as the law(s) and policy(ies) specified below.

- [insert NCAC citation, C.F.R., or other applicable law or title of specific medical policy supporting decision]
- United States Code [insert code]
- United States Code 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act]

Recipient Name [insert]
MID # [insert]

DMA 2002E
09/08/05
REV 09/24/08

Notice of Decision on a Continuing Request for Medicaid Services (EPSDT) (DMA 2002E), page 3

- North Carolina Administrative Code [insert code]
- North Carolina Administrative Code 10A NCAC 22O .0301

Medicaid's clinical coverage policies can be found on its website at http://www.ncdhhs.gov/dma/mp/mpindex.htm.

YOU HAVE THE RIGHT TO APPEAL THIS DECISION. If you decide to appeal the decision, you must file for an evidentiary hearing with the Office of Administrative Hearings. **YOU HAVE 30 DAYS FROM THE DATE THIS DECISION LETTER WAS MAILED TO FILE THE REQUEST FOR HEARING.**

To learn more about the hearing process or to speak with a Medicaid clinical policy analyst about this decision, call the Appeals Coordinator, Division of Medical Assistance at 919-855-4260. You may also call the toll free **CARE-LINE, Information and Referral Services, at 1-800-662-7030** and request that your call be transferred. The enclosed general information sheet also explains the hearing process.

THE HEARING PROCESS AND FILING THE REQUEST:

- Hearings are conducted by an administrative law judge with the Office of Administrative Hearings (OAH).
- To file for a hearing, you must submit **a completed hearing request form** (enclosed in this mailing). You can also obtain a hearing request form by calling the Division of Medical Assistance at the number specified above, or you can call the Office of Administrative Hearings at 919-431-3000.
- Mail or fax the completed hearing request form to Clerk, Office of Administrative Hearings **AND** General Counsel, North Carolina Department of Health and Human Services at the addresses or fax numbers on the enclosed hearing request form. **The completed form must be filed within 30 days of the date this decision letter was mailed**. As the mailing date is located on the envelope, **please keep the envelope containing this decision letter**.
- The Office of Administrative Hearings or the Mediation Network of North Carolina will contact you to discuss your case and to offer an opportunity for mediation in an effort to resolve your appeal. If mediation resolves your case, your hearing will be dismissed, and services will be provided as specified by the Mediation Network of North Carolina.
- If you do not accept the offer of mediation or the results of mediation, your case will proceed to hearing. You will be notified by mail of the date, time, and location of your hearing.
- The administrative law judge will make a decision and will send that decision to Medicaid for a final agency decision. You will receive a written copy of both the administrative law judge's decision and Medicaid's final agency decision.
- If you do not agree with Medicaid's final agency decision, you may ask for a judicial review in superior court.
- You may represent yourself in the hearing process, hire an attorney, or ask a relative, friend, or other spokesperson to speak for you.

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Recipient Name [insert]
MID # [insert]

DMA 2002E
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Notice of Decision on a Continuing Request for Medicaid Services (EPSDT) (DMA 2002E), page 4

- If a **continuing** request for services is denied and you submit a request for hearing within **30 days of the date this decision letter was mailed and** as long as you remain otherwise Medicaid eligible, unless you give up this right, you are entitled to receive services during the pendency of the appeal. **This right to receive services applies even if you change providers.** Services will be provided at the same level you were receiving the day before the decision or the level requested by your provider, whichever is less. The services that continue must be based on your current condition and must be provided in accordance with all applicable state and federal statutes and rules and regulations.
- If you lose your appeal, you may be required to pay for the services that continue because of the appeal.

Free legal aid may be available to assist with your appeal. Contact your nearest Legal Aid of North Carolina office or call 1-919-856-2564 or toll-free at 1-866-369-6923 to obtain the telephone number of the office that serves your community.

Sincerely,

[insert contact name and credentials]
[insert telephone # of contact]

Enclosure: Recipient Hearing Request Form, DMA 2003
(Only the recipient may appeal the decision).

C: Provider
Appeals Coordinator, Division of Medical Assistance
Office of Administrative Hearings

Recipient Name [insert]
MID # [insert]

DMA 2002E
09/08/05
REV 09/24/08

Notice of Decision on a Continuing Request for Medicaid Services (EPSDT) (DMA 2002E), page 5

POSSIBLE PARAGRAPH 1 SAMPLES

DO NOT INCLUDE WITH NOTICE

Example #1: The above named provider requested prior authorization for Community Support Services at an intensity of 416 units for a 90 day period. After reviewing the request, Medicaid **reduced** the request effective **30 days from the date this notice was mailed**. Two hundred units are authorized for the period October 15-November 25, 2008 or October 15, 2007-January 14, 2009.

Example #2: The above named provider requested prior authorization for Community Support Services at an intensity of 416 units for a 90 day period. After reviewing the request, Medicaid **changed** the request. Community Support Team is authorized at 1,820 units for the period October 01-December 29, 2008. The decision is effective **30 days from the date this notice was mailed**.

Example #3: The above named provider requested prior authorization for skilled level of care. After reviewing the request, Medicaid **reduced** the request to intermediate level of care effective **30 days from the date this notice was mailed**.

Example #4: The above named provider requested prior authorization for physical therapy at an intensity of 45 units for a 60 day period. After reviewing the request, Medicaid **terminated** the service effective **30 days from the date this notice was mailed**.

POSSIBLE EXAMPLES FOR PARAGRAPH #1 SUGGESTED BY VO

While the scenarios are written for behavioral health services, they should work for services that have similar request patterns. They should also work for services that have no time frames or units by deleting them from the samples. These scenarios in their entirety would be substituted for paragraph #1, page 1.

Concurrent Request – Reduction – Community Support: Request for 416 units (8 hrs/wk) of Community Support from 10/1/08 – 12/30/08. Peer Advisor decision is to authorize 4 hrs/wk. Letter date is 10/1/08. Total authorized units accommodate 8 hrs/wk for 30 days from letter date, and then 4 hrs/week for the remainder of the authorization period. Suggested paragraph:

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Recipient Name [insert]
MID # [insert]

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Notice of Decision on a Continuing Request for Medicaid Services (EPSDT) (DMA 2002E), page 6

The above named provider requested prior authorization for 416 units of Community Support Services from October 1, 2008 – December 30, 2008. After reviewing the documentation submitted by the provider, Medicaid **reduced** this request. Medicaid has authorized 277 units for the period October 1, 2008 – December 30, 2008. **This authorization includes units at the lesser of the previous or requested rate for the first 30 days, with the reduction applied to the remaining days of the authorization period.** The decision is effective **30 days from the date this notice was mailed**.

Concurrent Request – Reduction - Residential: Request for 60 days of Residential services from 10/1/08 – 11/29/08. Peer Advisor decision is to deny ongoing Residential services. Letter date is 10/1/08.

The above named provider requested prior authorization for 60 days of Residential Services from October 1, 2008 – November 29, 2008. After reviewing the documentation submitted by the provider, Medicaid **reduced** this request. Medicaid has authorized 30 days for the period October 1, 2008 – October 30, 2008. The decision is effective **30 days from the date this notice was mailed**.

Concurrent/Continuing Request – Changed (Different service approved than requested)

Request for 416 units (8 hrs/wk or 32 units) of Community Support from 10/1/08 – 12/30/08. Decision is to authorize Community Support Team at 140 units per week (35 hours) for the period requested. Letter date is 09/1/08. Suggested paragraph:

The above named provider requested prior approval for [insert name of service] from [insert period—October 01–November 29, 2008-if applicable]. After reviewing the documentation submitted by the provider, Medicaid **changed** this request. Medicaid **approved** [insert: service/procedure, # of units and time period, if relevant] effective **30 days from the date this notice was mailed**.

Concurrent/Continuing Request - Terminated

Request for 416 units of Community Support Services is requested from 10/1/08 – 12/30/08. Decision is a straight termination. Letter date is 09/01/08. Suggested paragraph:

The above named provider requested prior approval for [insert #] units of [insert name of service] from [insert time period—i.e., October 1-December 30, 2008 or November 01, 2008-January 01, 2009]. After reviewing the documentation submitted by the provider, Medicaid **terminated** the service. The decision is effective **30 days from the date this notice was mailed**.

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Recipient Name [insert]
MID # [insert]

DMA 2002E
09/08/05
REV 09/24/08

Notice of Return Request to Provider (DMA 3503)

[Insert LME Letterhead]

NOTICE OF RETURN REQUEST TO PROVIDER

[insert date notice to be mailed]

Provider Name
Provider Address

Recipient's or Legal Rep's Name
Address

RE: [insert recipient name if known and delete RE if unknown]
MID: [insert MID # if known and delete MID if unknown]

Dear [insert provider name]:

Medicaid received your correspondence dated [insert date of correspondence] in which you requested prior authorization of a Medicaid service. Your request cannot be processed because it did not identify [insert all applicable: the recipient's name, address, Medicaid identification (MID) number or date of birth, provider contact information, date of request, or the procedure, service, or product being requested].

To initiate a prior approval request, please refer to the Basic Medicaid Billing Guide. The Guide explains how to request prior approval. The publication is located on the DMA website at http://www.ncdhhs.gov/dma/medbillcaguide.htm.

Recipient appeal rights are not implicated as no action could be taken on this request. For your convenience, your correspondence is enclosed in this mailing.

Please contact me at the telephone indicated below if you have questions.

Sincerely,

[insert name and credentials]
[insert title]
[insert telephone number]

DMA 3503
09/08/05
REV. 09/24/08

Notice of Request for Additional Information (DMA 3501), page 1

[Insert LME Letterhead]

NOTICE OF REQUEST FOR ADDITIONAL INFORMATION

[insert date to be mailed]

Provider Name
Provider Address

RE: [insert recipient name]
MID: [insert MID #]

Dear [insert provider name]:

The Division of Medical Assistance (DMA) has received a request for a [insert service, product, or procedure requested] on behalf of the recipient referenced above. As a part of the review process, it is necessary to review documentation related to the recipient's condition.

The Division of Medical Assistance and its contractual agents are authorized access to patient records by Federal Statute Social Security Act 1902 (a) (27) and Federal Regulation 42 CFR 431.107 for purposes directly related to the administration of the Medicaid program, and no special permission is required. Additionally, for health oversight activities authorized by law, the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule provides that protected health information (PHI) may be used and disclosed without the authorization of the patient. The Privacy Rule can be found at 45 CFR Part 164.502 and .508. It should be noted that upon acceptance of Medicaid eligibility, recipients grant the state Medicaid agency, the Division of Medical Assistance, the right to access medical records.

North Carolina Medicaid requires the provider of services to keep any records necessary to disclose the extent of services furnished and upon request, furnish to the Medicaid agency and its authorized representatives any and all information contained in medical records.

Please send copies of the medical information specified below that document the condition of the recipient related to the request for [insert name of service, product or procedure requested or denied].

List the records needed. (The HIPAA Privacy Rule requires that only the amount of information that is needed to accomplish the purpose of the request be submitted. Only request the complete medical record if it is really needed, otherwise specify the specific documents/information that is required to complete the review).

No later than **15 business days from the date of this notice**, the required information specified above must either be submitted or contact must be made with the person indicated below to

Recipient [insert name]
MID #: [insert number]

DMA 3501
10/05
REV 09/24/08

Notice of Request for Additional Information (DMA 3501), page 2

provide a reasonable date that the additional information can be provided. Failure to respond to this notice within the required timeframe shall result in a denial of the request. Mail or fax copies of the above referenced information to:

[insert staff name]
LME Name
LME Address
City, NC Zip
Fax number: [insert number]

Please contact me at the telephone number specified below if you have any questions concerning this request.

Sincerely,

[insert name and credentials]
[insert title]
[insert telephone number]

Recipient [insert name]
MID #: [insert number]

DMA 3501
10/05
REV 09/24/08

Notice of Request for Additional Information (EPSDT) (DMA 3501E), page 1

[Insert LME Letterhead]

NOTICE OF REQUEST FOR ADDITIONAL INFORMATION

[insert date to be mailed]

Provider Name
Provider Address

RE: [insert recipient name]
MID: [insert MID #]

Dear [insert provider name]:

The Division of Medical Assistance (DMA) has received a request for a [insert service, product, or procedure requested] on behalf of the recipient referenced above. As a part of the review process, it is necessary to review documentation related to the recipient's condition.

The Division of Medical Assistance and its contractual agents are authorized access to patient records by Federal Statute Social Security Act 1902 (a) (27) and Federal Regulation 42 CFR 431.107 for purposes directly related to the administration of the Medicaid program, and no special permission is required. Additionally, for health oversight activities authorized by law, the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule provides that protected health information (PHI) may be used and disclosed without the authorization of the patient. The Privacy Rule can be found at 45 CFR Part 164.502 and .508. It should be noted that upon acceptance of Medicaid eligibility, recipients grant the state Medicaid agency, the Division of Medical Assistance, the right to access medical records.

North Carolina Medicaid requires the provider of services to keep any records necessary to disclose the extent of services furnished and upon request, furnish to the Medicaid agency and its authorized representatives any and all information contained in medical records.

Please send copies of the medical information specified below that document the condition of the recipient related to the request for [insert name of service, product or procedure requested or denied].

List the records needed. (The HIPAA Privacy Rule requires that only the amount of information that is needed to accomplish the purpose of the request be submitted. Only request the complete medical record if it is really needed, otherwise specify the specific documents/information that is required to complete the review).

[Insert next three paragraphs if EPSDT information is needed. If not needed, delete.]
As the recipient is under 21 years of age, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) apply. EPSDT makes services available to recipients under 21 years of age without many of the restrictions Medicaid imposes for services under a waiver **OR** for adults (recipients over 21 years of age). Specifically, the service limitations on scope, amount, duration, frequency, and other specific criteria described in DMA's clinical coverage policies may be exceeded or may not apply if documentation submitted by the provider shows that all

DMA 3501E
10/05
REV 09/24/08

Notice of Request for Additional Information (EPSDT) (DMA 3501E), page 2

EPSDT criteria are met. The services must be prescribed by the recipient's physician, therapist, or other licensed practitioner.

When a recipient is under 21 years of age, the provider's request for service is evaluated under the applicable Medicaid clinical coverage policies as well as the EPSDT criteria if all clinical coverage policy criteria are not met. To expedite this review, please provide information about the criteria specified below.

[Insert all that apply or delete if not requesting EPSDT information. Double space between paragraph before and after EPSDT criteria.]

- EPSDT services must be coverable services within the scope of those listed in the federal law at 42 U.S.C. § 1396d(a) [1905(a) of the Social Security Act].
- The service must be medically necessary to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] diagnosed by the recipient's physician, therapist, or other licensed practitioner.
- The requested service must be determined to be medical in nature.
- The service must be safe.
- The service must be effective.
- The service must be generally recognized as an accepted method of medical practice or treatment.
- The service must not be experimental/investigational.

No later than **15 business days from the date of this notice**, the required information specified above must either be submitted or contact must be made with the person indicated below to provide a reasonable date that the additional information can be provided. Failure to respond to this notice within the required timeframe shall result in a denial of the request. Mail or fax copies of the above referenced information to:

[insert staff name]
LME Name
LME Address
City, NC Zip
Fax number: [insert number]

Please contact me at the telephone number specified below if you have any questions concerning this request.

Sincerely,

[insert name and credentials]
[insert title]
[insert telephone number]

Recipient [insert name]
MID #: [insert number]

DMA 3501E
10/05
REV 09/24/08

Notice of Denial of Service Request – Additional Information Previously Requested and Not Received (DMA 2001A), page 1

[Insert LME Letterhead]

NOTICE OF DENIAL OF SERVICE REQUEST
Additional Information Previously Requested and Not Received

[insert date to be mailed]

Recipient's or Legal Rep's Name
Address

Provider Name
Provider Address

RE: [insert recipient name]
MID: [insert MID #]

Dear [insert name of recipient or parent/guardian/authorized representative]:

On [insert date], [insert name of physician, recipient or other person who requested service] asked Medicaid to authorize a prior approval request for [insert specific service/procedure requested and time period if relevant]. Medicaid **denied** the request effective [if an initial request, insert: **the date this letter was mailed** or if currently receiving services, insert: **30 days from the date this letter was mailed**. This letter explains why the request was denied and tells you how to appeal this decision if you disagree.

Medicaid denied the request because medical necessity could not be validated. Specifically, Medicaid sent your provider a letter dated [insert date of notice for additional information—October 01, 2008], requesting additional information in an effort to determine if Medicaid could authorize the prior approval request as indicated above. This information was due [insert due **date** for additional information], and, to date, it has not been received, and the provider did not request an extension of time to submit the additional information. The law or policy the denial is based on is 10A NCAC 22O .0301. The North Carolina Administrative Code can be found at http://reports.oah.state.nc.us/ncac.asp.

While you have the right to appeal this decision, the provider may submit a new request at any time along with the additional information requested in the letter dated [insert date of notice for additional information] to the address specified below.

[insert name and credentials]
LME Name
Address
City, NC Zip

Si desea apelar esta decisión, debe responder a no más tardar de 30 días a partir de la fecha que esta carta fue enviada. Si necesitas ayuda para leer y entender la carta, por favor contáctese con el 1-800-662-7030. DIGA AL OPERADOR QUE LA NOTIFICACION DMA 2001A.

DMA 2001A
09/08/05
REV 09/24/08

Notice of Denial of Service Request – Additional Information Previously Requested and Not Received (DMA 2001A), page 2

YOU HAVE THE RIGHT TO APPEAL THIS DECISION. If you decide to appeal the decision, you must file for an evidentiary hearing with the Office of Administrative Hearings. **YOU HAVE 30 DAYS FROM THE DATE THIS DECISION LETTER WAS MAILED TO FILE THE APPEAL REQUEST.**

To learn more about the hearing process or to speak with a Medicaid clinical policy analyst about this decision, call the Appeals Coordinator, Division of Medical Assistance at 919-855-4260. You may also call the toll free **CARE-LINE, Information and Referral Services, at 1-800-662-7030** and request that your call be transferred**.** The enclosed general information sheet also explains the hearing process.

THE HEARING PROCESS AND FILING THE REQUEST:

- Hearings are conducted by an administrative law judge with the Office of Administrative Hearings (OAH).
- To file for a hearing, you must submit **a completed hearing request form** (enclosed in this mailing). You can also obtain a hearing request form by calling the Division of Medical Assistance at the number specified above, or you can call the Office of Administrative Hearings at 919-431-3000.
- Mail or fax the completed request form to Clerk, Office of Administrative Hearings **AND** General Counsel, North Carolina Department of Health and Human Services at the addresses or fax numbers on the enclosed hearing request form. **The completed form must be filed within 30 days of the date this decision letter was mailed**. As the mailing date is located on the envelope, **please keep the envelope containing this decision letter**.
- The Office of Administrative Hearings or the Mediation Network of North Carolina will contact you to discuss your case and to offer an opportunity for mediation in an effort to resolve your appeal. If mediation resolves your case, your hearing will be dismissed, and services will be provided as specified by the Mediation Network of North Carolina.
- If you do not accept the offer of mediation or the results of mediation, your case will proceed to hearing. You will be notified by mail of the date, time, and location of your hearing.
- The administrative law judge will make a decision and will send that decision to Medicaid for a final agency decision. You will receive a written copy of both the administrative law judge's decision and Medicaid's final agency decision.
- If you do not agree with Medicaid's final agency decision, you may ask for a judicial review in superior court.
- You may represent yourself in the hearing process, hire an attorney, or ask a relative, friend, or other spokesperson to speak for you.
- Insert only if receiving services: If a **continuing** request for services is denied and you submit a request for hearing within **30 days of the date this decision letter was mailed and** as long as you remain otherwise Medicaid eligible, unless you give up this right, you are entitled to receive services during the pendency of the appeal. **This right to receive services applies even if you change providers.** Services will be

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Recipient Name [insert]
MID # [insert]

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09/08/05
REV 09/24/08

Notice of Denial of Service Request – Additional Information Previously Requested and Not Received (DMA 2001A), page 3

provided at the same level you were receiving the day before the decision or the level requested by your provider, whichever is less. The services that continue must be based on your current condition and must be provided in accordance with all applicable state and federal statutes and rules and regulations.

- Insert only if receiving services: If you lose your appeal, you may be required to pay for the services that continue because of the appeal.

Free legal aid may be available to assist with your appeal. Contact your nearest Legal Aid of North Carolina office or call 919-856-2564 or toll-free at 1-866-369-6923 to obtain the telephone number of the office that serves your community.

Sincerely,

[insert contact name and credentials]
[insert telephone # of contact]

Enclosure: Recipient Hearing Request Form, DMA 2003
(Only the recipient may appeal the decision).

C: Provider
Office of Administrative Hearings
Appeals Coordinator, Division of Medical Assistance

Recipient Name [insert]
MID # [insert]

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Attachment K: Discharge from Treatment Form

Discharge from Treatment

Please complete and submit (electronically or by fax) this Discharge Form for your consumer as soon as you confirm a Discharge Date. If this is an unplanned, patient directed discharge, submit this form as soon as you are aware of the fact that your consumer has discontinued using your services.

Discharge Date: ____/____/____

Level of Service:
☐Inpatient; ☐Residential: ☐Outpatient Enhanced; ☐ Outpatient Basic
Type of Service:
☐Mental Health; ☐Substance Abuse; ☐Developmental Disability

Patient Name: _____
Date of Birth: _____ Age: _____ ☐M ☐F
Address: _____
Tel #:_____ Patient MID#: _____

Provider Name: _____
NPI: _____ CIS Provider #: _____
Site Address: _____
City/State/Zip: _____
Tel #: _____

Clinical Information
Discharge DSM-IV Diagnoses (Axes I-III): _____
_____
_____
Discharge Condition: ☐Improved; ☐No Change; ☐Worse; ☐Unknown
Type of Discharge: ☐Planned; ☐Unplanned
Discharge Reasons: (*Check all that apply*)
☐No further treatment indicated/stable
☐Consumer chose to disengage at this time
☐Referred for less intensive level of service
New provider/service: _____
☐Referred to more intensive level of service
New provider/service: _____
☐Consumer chose other outpatient provider/service
New provider/service: _____
☐No longer eligible for this service
☐Consumer moved out of provider's area of service
☐Attempts to contact consumer have been unsuccessful
☐Incarceration
☐Other: _____

Current Risk Assessment:
0 = none; 1 = mild, ideation only; 2 = moderate, ideation with EITHER plan or history of attempts; 3 = severe, ideation AND plan, with either intent or means; na = not assessed
(Please select/circle one value for each type of risk)
Patient's risk to self: 0 1 2 3 na
With: ☐Ideation; ☐Intent; ☐Plan; ☐Means
Patient's risk to others: 0 1 2 3 na
With: ☐Ideation; ☐Intent; ☐Plan; ☐Means

Current Impairments: *(Please select/circle one value for each type of impairment)*
0=none; 1=mild/mildly incapacitating; 2=moderate/moderately incapacitating;3=severe or severely incapacitating; na=not assessed

Mood Disturbance (Depression or Mania):	0	1	2	3	na
Anxiety:	0	1	2	3	na
Psychosis/Hallucinations/Delusions:	0	1	2	3	na
Thinking/Cognition Problems:	0	1	2	3	na
Memory Problems:	0	1	2	3	na
Concentration Problems:	0	1	2	3	na
Impulsivity:	0	1	2	3	na
Reckless/Aggressive Behavior:	0	1	2	3	na
Activities of Daily Living Problems:	0	1	2	3	na
Weight Change (due to Behavioral Diagnosis):	0	1	2	3	na
Medical/Physical Condition:	0	1	2	3	na
Substance Abuse/Dependence:	0	1	2	3	na
Job/School Performance Problems:	0	1	2	3	na
Social/Relationship/Marital/Family Problems:	0	1	2	3	na
Legal Problems:	0	1	2	3	na

Treating Clinician (please print):
_____
Licensure level (if applicable): _____

Treating Provider's Signature:
_____
Date Form Completed: _____

FAX to: [Insert LME information here]

UM002 Rev11032008

Attachment L: Recipient Hearing Request Form

General Information About the Hearing Process

FOR YOUR INFORMATION ONLY
DO NOT SEND THIS PAGE WITH A COMPLETED HEARING REQUEST FORM.

GENERAL INFORMATION ABOUT THE HEARING PROCESS

UNDERSTANDING THE APPEAL PROCESS: If you choose to appeal, you may represent yourself during the appeal process, hire an attorney, or ask a relative, friend, or other spokesperson to speak for you. Your case will begin as soon as the completed recipient hearing request form that you were sent in this mailing is **received and filed** with the Office of Administrative Hearings (OAH) **AND** the Department of Health and Human Services (DHHS). You will be contacted by the Office of Administrative Hearings or the Mediation Network of North Carolina to discuss your case and to be offered an opportunity for mediation in an effort to resolve your appeal. If mediation resolves your case, your hearing will be dismissed, and services will be provided as specified by the Mediation Network of North Carolina. If you do not accept the offer of mediation or the results of mediation, your case will proceed to hearing and will be heard by an administrative law judge with the Office of Administrative Hearings. You will be notified by mail of the date, time, and location of your hearing. The administrative law judge will make a decision and will send that decision to Medicaid for a final agency decision. You will receive a written copy of both the administrative law judge's decision and Medicaid's final agency decision. If you do not agree with Medicaid's final agency decision, you may ask for a judicial review in superior court. The hearing process must be completed within 90 days of receipt of your completed Recipient Hearing Request Form. For more information about the hearing process, visit the websites indicated below.

- **Adults:** http://www.ncdhhs.gov/dma/Forms/abd.pdf.
- **Children:** http://www.ncdhhs.gov/dma/Forms/famchld.pdf.

SERVICES DURING THE APPEAL PROCESS: If a **continuing** request for services is denied and you submit a request for hearing within **30 days of the date this decision letter was mailed** **and** as long as you remain otherwise Medicaid eligible, unless you give up this right, you are entitled to receive services during the pendency of the appeal. **This right to receive services applies even if you change providers.** The service will be provided at the same level you were receiving the day before the decision or the level requested by your provider, whichever is less. The services that continue must be based on your current condition and must be provided in accordance with all applicable state and federal statutes and rules and regulations. If you lose your appeal, you may be required to pay for the services that continue because of the appeal.

FILING A RECIPIENT HEARING REQUEST FORM WITH OAH AND DHHS: Complete the enclosed Recipient Hearing Request Form if you decide to appeal Medicaid's decision to deny, terminate, reduce (change), or suspend the services requested by your provider. Hearing requests must be served on **BOTH** OAH and DHHS. The request must be filed by mail or fax within **30 days of the date the notice was mailed**. The mailing addresses and telephone and fax numbers for OAH and DHHS appear below.

For questions concerning the decision Medicaid made about your provider's request for service, please contact Medicaid. Should you have questions about the appeal process, please contact OAH. You may also contact the Appeals Unit, Division of Medical Assistance (Medicaid) if you have questions.

AGENCY	MAILING ADDRESS	OFFICE NUMBER	FAX NUMBER
Office of Administrative Hearings (OAH)	Clerk 6714 Mail Service Center Raleigh, NC 27699-6714	919-431-3000	Clerk 919-431-3100
NC Department of Health and Human Services (DHHS)	General Counsel 2001 Mail Service Center Raleigh, NC 27699-2001	919-733-4534	General Counsel 919-715-4645
Division of Medical Assistance (Medicaid)	Appeals Unit Clinical Policy and Programs 2501 Mail Service Center Raleigh, NC 27699-2501	919-855-4260 Toll-free: 1-800-662-7030 Ask for your call to be transferred to the DMA Appeals Unit, Clinical Policy and Programs.	Appeals Unit 919-733-2796

DMA 2003
09/08/05
REV 09/24/08

Recipient Hearing Request Form (DMA 2003)

RECIPIENT HEARING REQUEST FORM

COMPLETE THIS FORM IF YOU WISH TO APPEAL MEDICAID'S DECISION

Date: [insert date of notice (must be date notice mailed)] **Period: [insert period/date range of service, if applicable]**
Decision made by: ____DMA____ACS____CCME____EDS____Murdoch____PBH____VO
Type of Request: ____Initial/No Service in Place____Continuing/Concurrent
Type of Notice Issued: ____2001____2001A____2001E____2001NCS____2002____2002E

SEND COPY OF FORM TO:
Office of Administrative Hearings (OAH)
Attention: Clerk
6714 Mail Service Center
Raleigh, NC 27699-6714
Telephone: 919-431-3000
Fax: 919-431-3100

SEND COPY OF FORM TO:
Department of Health and Human Services (DHHS)
Attention: General Counsel
2001 Mail Service Center
Raleigh, NC 27699-2001
Telephone: 919-733-4534
Fax: 919-715-4645

[Insert name of Medicaid recipient] (MID #) [insert MID # in ()]
Address [insert street address of Medicaid recipient]
City, State Zip code [insert city, state, and zip code]

DIRECTIONS: Please complete the Recipient Hearing Request Form if you decide to appeal Medicaid's decision to [insert deny, terminate, reduce (change), or suspend] services. Send the completed request form by mail or fax to OAH AND DHHS at the addresses or fax numbers in the above boxes. The hearing request form must be received within **30 days of the date this notice was mailed**. You may represent yourself during the appeal process, hire an attorney, or ask a relative, friend, or other spokesperson to represent you. By signing this form, you authorize the person(s) listed below to represent you during the appeal, to discuss your case, and to release any and all medical records or other documents and confidential information that pertain to the hearing. You also attest that **BOTH** OAH and DHHS have been served.

I would like to appeal the [insert termination, denial, or reduction] of [insert service being terminated, denied, or reduced] or [insert change in service from (insert requested service) to (insert approved service)].

Please check one.

☐ I will represent myself.

☐ I will be represented by someone else other than myself. If yes, please provide the information requested below.

Name of Representatives	Relationship to Recipient	Address	Telephone Number
			( )_____-_____
			( )_____-_____

If a **continuing** request for services is denied and you submit a request for hearing within **30 days of the date this decision letter was mailed and** as long as you remain otherwise Medicaid eligible, unless you give up this right, you are entitled to receive services during the pendency of the appeal. **This right to receive services applies even if I change providers.** Services will be provided at the same level I was receiving the day before the decision or the level requested by my provider, whichever is less. The services that continue must be based on my current condition and must be provided in accordance with all applicable state and federal statutes and rules and regulations. If I lose my appeal, I understand that I may be required to pay for the services that continue because of the appeal.

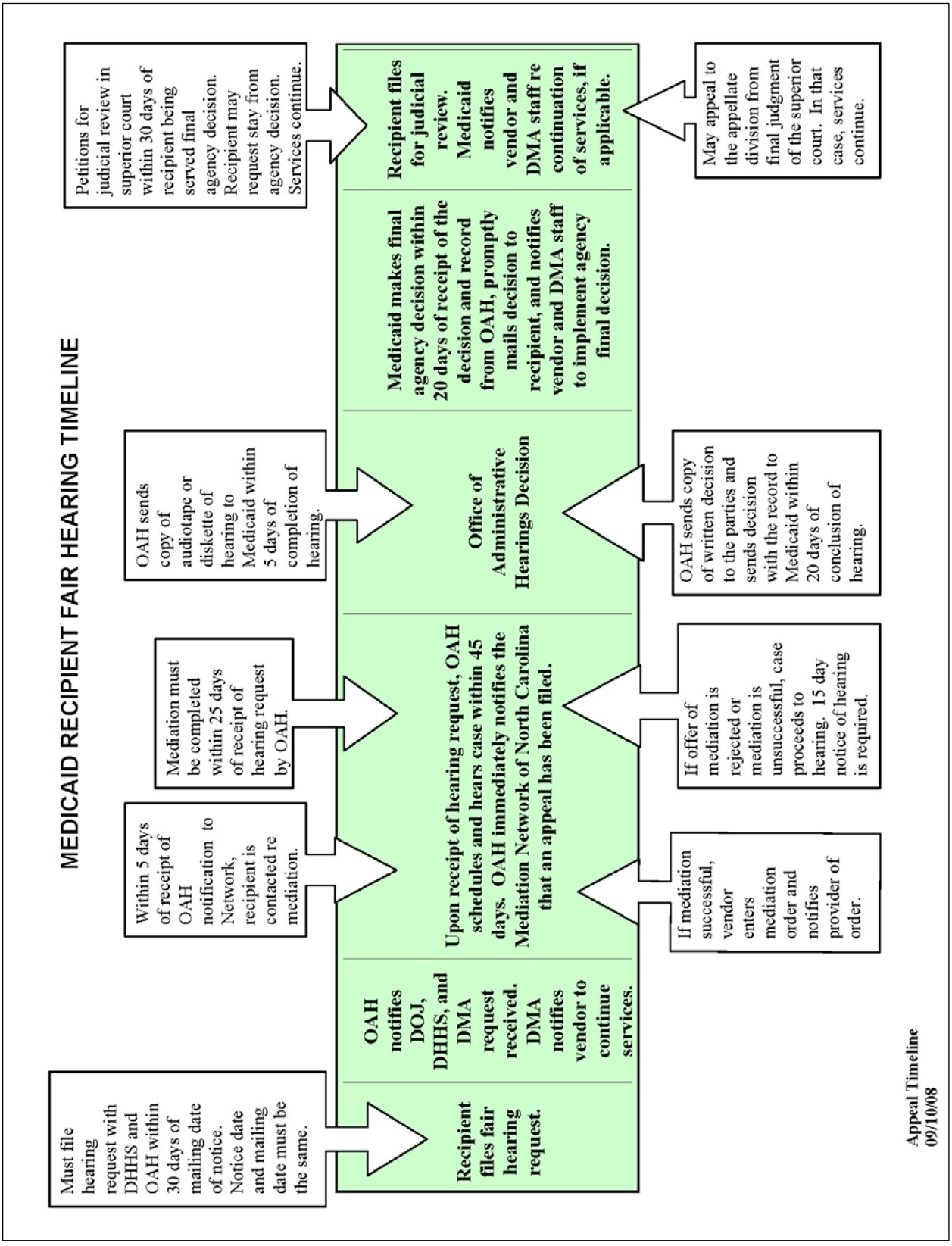
_____ _____ (_____)_____
Signature of Medicaid Recipient/Applicant or Legal Representative Date Telephone Number

Print Name of Medicaid Recipient/Applicant or Legal Representative: _____
Full Mailing Address: _____

DMA 2003
09/08/05
REV 09/24/08

DMA 2003 is in compliance with S.L. 2008-118, s. 313(a), effective July 01, 2008.

Attachment M: Medicaid Recipient Fair Hearing Timeline



Attachment N: HIPAA Breach Report

HIPAA BREACH REPORT

INSTRUCTIONS

NOTE: This is an administrative report; DO NOT include in any agency designated record set(s), including client health records.

SECTION I – GENERAL INFORMATION

Name of Staff Member Reporting Incident			
Telephone Number	( ) - x	Email Address	
LME Entity			
Unit/Section			
Supervisor			

SECTION II – PRIVACY INCIDENT INFORMATION

Date of Incident _____ **Time of Incident** _____ **Location of Incident** _____

Description of Incident (Include the names of those involved in the privacy incident.)

Incident also reported to _____

Signature/Title: _____ Date: _____

(Staff member reporting privacy incident)

Supervisor Comments

Signature/Title: _____ Date: _____

(Supervisor of staff member reporting privacy incident)

Attachment O: LME PA Authorization Inbound File Layout

LME PA Authorization Inbound File Layout, page 1

Item #	EDS Data Element/Structure	Field Description	Data Type	Field Length	Edit Format	Data Required /Optional	Starting Position	Ending Position
1	SUBMITTAL-ID	'01' = LME 1 '02' = LME 2 '03' = LME 3 '04' = LME 4 '05' = LME 5	A/N	2		Required - Value must be between '01' and '99 and unique to each submitting entity	1	2
2	SERVICE TYPE	I = Inpatient (Includes OOS) M = Independent MH O = Outpatient P = PRTF (Includes OOS) R = Residential Child Care (Includes OOS) H = High Risk E = Enhanced Services C = CAP T = Targeted Case Mgmt. D = EPSDT	A/N	1		Required – must be one of the following: 'I', 'M', 'O', 'P', 'R', 'H', 'E', 'C', 'T', or 'D'	3	3
3	SUB-SEC-CODE	Submittal Security Code	A/N	4	'LMEI'	Required	4	7
4	STATE-CODE	State Code	A/N	2	'NC'	Required	8	9
5	MID	Medicaid Identification Number	A/N	10		Required - Must be the Base ID/ Medicaid ID	10	19
6	RECIPIENT-LNAME	Recipient's Last Name	A	20		Required	20	39
7	RECIPIENT-FNAME	Recipient's First Name	A	9		Required	40	48
8	RECIPIENT-DOB	Recipient's Date of Birth	N	8	MMDDCCYY	Required	49	56
9	START-DATE	PA Starting Date	N	8	MMDDCCYY	Required	57	64
10	END-DATE	PA Ending Date	N	8	MMDDCCYY	Optional	65	72
11	UNITS-APPROVED	Number of Units Approved	N	4		Optional	73	76
12	PA-NUMBER	PA Number	A/N	13		Required – Must be unique for	77	89

LME PA Authorization Inbound File Layout, page 2

Item #	EDS Data Element/Structure	Field Description	Data Type	Field Length	Edit Format	Data Required /Optional	Starting Position	Ending Position
						each LME		
13	ADMISSION-DATE	Date of Recipient admission	N	8	MMDDCCYY	Optional	90	97
14	PROVIDER	Provider Number	A/N	13		Required	98	110
15	REFER-PROVIDER	Provider Number which referred Recipient	A/N	13		Required	111	123
16	DIAG-CODE1	Diagnosis Code 1	A/N	5		Optional	124	128
17	DIAG-CODE2	Diagnosis Code 2	A/N	5		Optional	129	133
18	DIAG-CODE3	Diagnosis Code 3	A/N	5		Optional	134	138
19	PROCEDURE-CODE	Procedure Code	A/N	5		Required	139	143
20	REC-TYPE	A = add new segment C = change existing segment	A/N	1	'A', 'C'	Required	144	144
21	PA-STATUS	A = Approved B = Denied/Administrative D = Denied P = Pending R = Returned V = Void	A/N	1	'A', 'B', 'D', 'P', 'R' or 'V'	Required	145	145
22	MOD CODE	SERVICE MODIFIER CODE	A	2		Required	146	147

LME PA Authorization Inbound File Layout, page 3

Item #	EDS Data Element/Structure	Field Description	Data Type	Field Length	Edit Format	Data Required /Optional	Starting Position	Ending Position
23	ORIG-UNITS	Original Units	N	4		Required	148	151
24	READMIT-IND	Readmit Indicator	A	1	'A' – Readmitted within to same facility within 30 Days 'B' – Readmitted to same facility within 90 days C' – Readmitted within to different facility within 30 Days 'D' – Readmitted to different facility within 90 days	Optional	151	151
25	EPSDT-IND	EPSDT PA	A	1	Y = EPSDT	Optional	152	152152
26	REFERRAL-IND	Referred by	A	1	'P' = Peer Referral	Optional	153	153
27	REDUCED-IND	Reduced by indicator	A	1	'P' = Reduced by Peer Review 'C' = Reduced by CCM With Provider Agreement	Optional	154	154
28	DECISION-COUNT	Total Number of decisions	N	3		Required	155	157
29	DENIED-IND	Denied by	A	1	'P' = Peer 'A' = Administrative	Optional	158	158
31	NUM-DAYS	Number of Days to completion	N	3		Required for Approved or Denied PA's	159	159
32	FILLER	FILLER	A/N	51		N/A	160	210
33	REC-ERROR-TABLE	Error Table Indicators – Not used on Inbound Transmissions	A/N	94		N/A	211	304

Attachment P: LME PA Authorization Outbound File Layout

LME PA Authorization Outbound File Layout, page 1

Item #	EDS Data Element/Structure	Field Description	Data Type	Field Length	Edit Format	Data Required /Optional	Starting Position	Ending Position
1	SUBMITTAL-ID	'01' = LME 1 '02' = LME 2 '03' = LME 3 '04' = LME 4 '05' = LME 5	A/N	2		Required - Value must be between '01' and '99 and unique to each submitting entity	1	2
2	SERVICE TYPE	I = Inpatient (Includes OOS) M = Independent MH O = Outpatient P = PRTF (Includes OOS) R = Residential Child Care (Includes OOS) H = High Risk E = Enhanced Services C = CAP T = Targeted Case Mgmt. D = EPSDT	A/N	1		Required – must be one of the following: 'I', 'M', 'O', 'P', 'R', 'H', 'E', 'C', 'T', or 'D'	3	3
3	SUB-SEC-CODE	Submittal Security Code	A/N	4	'LMEI'	Required	4	7
4	STATE-CODE	State Code	A/N	2	'NC'	Required	8	9
5	MID	Medicaid Identification Number	A/N	10		Required - Must be the Base ID/ Medicaid ID	10	19
6	RECIPIENT-LNAME	Recipient's Last Name	A	20		Required	20	39
7	RECIPIENT-FNAME	Recipient's First Name	A	9		Required	40	48
8	RECIPIENT-DOB	Recipient's Date of Birth	N	8	MMDDCCYY	Required	49	56
9	START-DATE	PA Starting Date	N	8	MMDDCCYY	Required	57	64
10	END-DATE	PA Ending Date	N	8	MMDDCCYY	Optional	65	72
11	UNITS-APPROVED	Number of Units Approved	N	4		Optional	73	76
12	PA-NUMBER	PA Number	A/N	13		Required – Must be unique for	77	89

LME PA Authorization Outbound File Layout, page 2

Item #	EDS Data Element/Structure	Field Description	Data Type	Field Length	Edit Format	Data Required /Optional	Starting Position	Ending Position
						each LME		
13	ADMISSION-DATE	Date of Recipient admission	N	8	MMDDCCYY	Optional	90	97
14	PROVIDER	Provider Number	A/N	13		Required	98	110
15	REFER-PROVIDER	Provider Number which referred Recipient	A/N	13		Required	111	123
16	DIAG-CODE1	Diagnosis Code 1	A/N	5		Optional	124	128
17	DIAG-CODE2	Diagnosis Code 2	A/N	5		Optional	129	133
18	DIAG-CODE3	Diagnosis Code 3	A/N	5		Optional	134	138
19	PROCEDURE-CODE	Procedure Code	A/N	5		Required	139	143
20	REC-TYPE	A = add new segment C = change existing segment	A/N	1	'A', 'C'	Required	144	144
21	PA-STATUS	A = Approved B = Denied/Administrative D = Denied P = Pending R = Returned V = Void	A/N	1	'A', 'B', 'D', 'P', 'R' or 'V'	Required	145	145
22	MOD CODE	SERVICE MODIFIER CODE	A	2		Required	146	147
23	ORIG-UNITS	Original Units	N	4		Required	148	151

LME PA Authorization Outbound File Layout, page 3

Item #	EDS Data Element/Structure	Field Description	Data Type	Field Length	Edit Format	Data Required /Optional	Starting Position	Ending Position
24	READMIT-IND	Readmit Indicator	A	1	'A' – Readmitted within to same facility within 30 Days 'B' – Readmitted to same facility within 90 days C' – Readmitted within to different facility within 30 Days 'D' – Readmitted to different facility within 90 days	Optional	151	151
25	EPSDT-IND	EPSDT PA	A	1	Y = EPSDT	Optional	152	152152
26	REFERRAL-IND	Referred by	A	1	'P' = Peer Referral	Optional	153	153
27	REDUCED-IND	Reduced by indicator	A	1	'P' = Reduced by Peer Review 'C' = Reduced by CCM With Provider Agreement	Optional	154	154
28	DECISION-COUNT	Total Number of decisions	N	3		Required	155	157
29	DENIED-IND	Denied by	A	1	'P' = Peer 'A' = Administrative	Optional	158	158
31	NUM-DAYS	Number of Days to completion	N	3		Required for Approve or Denied PA's	159	159
32	FILLER	FILLER	A/N	51		N/A	160	210
33	REC-ERROR-TABLE	Error Table Indicators – See Appendix A for valid values	A/N	94		N/A	211	304

Attachment Q: PA Authorization Error Codes

PA Authorization Error Codes, page 1

Error Number	Error Code	Reason
1	A	The submittal Id is not '01' thru '99'
2	B	The Service Type Id is not 'I' for Inpatient 'M' for Independent Mental Health 'O' for Outpatient 'P' for PRTF 'R' for Residential Child Care 'H' for High Risk 'E' for Enhanced Services 'C' for CAP 'T' for Targeted Case Management 'D' for EPSDT
3	C	Submittal Security Code is missing or invalid
4	D	State Code is missing or invalid
5	E	Medicaid Identification not eligible for Medicaid
6	F	First 15 characters of the Last Name of Recipient does not match the eligibility file
7	G	First 9 characters of the First Name of Recipient does not match the eligibility file
8	H	Recipient's Date of Birth does not match the eligibility file
9	I	PA Starting Date is not a valid date
10	J	When present the PA Ending Date is not a valid date
11	K	When required no Approved Units are present
12	L	No PA Number present
13	M	When present or required the Admission Date is not a valid date
14	N	Provider Number is missing
15	O	Provider Number is not on file
16	P	When present the Referring Provider Number is not on file
17	Q	When present the 1st Diagnosis Code is not a valid code
18	R	When present the 2ND Diagnosis Code is not a valid code
19	S	When present the 3rd Diagnosis Code is not a valid code
20	T	When present the Procedure Code or Modifier is not a valid code
21	U	Record Type is not 'A' for add or 'C' for change If 'A', it means Record already exist in PA Master If 'C', it means Record NOT present in PA Master or It is present but does not match the PA Start date
22	V	PA Status is not 'A' for approval, 'D' for denial, 'P' for Pending, 'R' for returned or 'V' for Void
23	W	Hospital Number is missing for High Risk Action Id
24	Y	Provider Type Invalid for High Risk Action Id
25	X	Procedure Code invalid / missing for High Risk Action Id
26	Z	Service Type ID, Procedure Code / Modifier combination is invalid
27	1	Outside Catchment Area
28	2	Invalid EPSDT Indicator – Recipient over 21

PA Authorization Error Codes, page 2

Error Number	Error Code	Reason
29	3	Referral Indicator Invalid
30	4	Readmission Indicator Invalid
31	5	Reduced By Indicator Invalid
32	6	When Required Original units not present
33	7	When Required Decision Count not present
34	8	When Present Denied By Indicator invalid
35	9	Disposition Indicator Invalid
36	A1	Alternate Provider Number Invalid
37	A2	Duplicate Record In Transmission
38	A3	Invalid Number of Days. Approved or Denied PA must have number of days to completion
39 - 47	A4 – B3	Reserved for future use

Attachment R: Weekly Summary Inbound File Layout

Item #	EDS Data Element/Structure	Field Description	Data Type	Field Length	Edit Format	Data Required /Optional	Starting Position	Ending Position
1	SUBMITTAL-ID	'01' = LME 1 '02' = LME 2 '03' = LME 3 '04' = LME 4 '05' = LME 5	A/N	2		Required - Value must be between '01' and '99 and unique to each submitting LME entity	1	2
2	SUMMARY DATA TYPE	I = Inpatient (Includes OOS) M = Independent MH O = Outpatient P = PRTF (Includes OOS) R = Residential Child Care (Includes OOS) H = High Risk E = Enhanced Services C = CAP T = Targeted Case Mgmt. D = EPSDT X = Summary Data	A/N	1		Required – must be one of the following: 'I', 'M', 'O', 'P', 'R', 'H', 'E', 'C', 'T', 'D', or 'X'	3	3
3	SUB-SEC-CODE	Submittal Security Code	A/N	4	'LMEI'	Required	4	7
4	STATE-CODE	State Code	A/N	2	'NC'	Required	8	9
5	WE-DATE	Week Ending Date	N	8	MMDDCCYY	Required	10	17
6	TOT-DIS-30	Total Discharges within 30 days	N	7	9999999	Required	18	24
7	TOT-DIS-90	Total Discharges within 90 days	N	7	9999999	Required	25	31
8	TOT-CALLS	Total Calls	N	7	9999999	Required	32	38
9	AVG-ANS-SPEED	Average Speed of answer per 1000 calls	N	7	9999999	Required	39	45
10	ABAN-RATE	Abandonment rate per 1000 calls	N	6	999.999	Required	46	51
11	FILLER	Future use	A/N	41		N/A	52	92
12	REC-ERROR-TABLE	Error Table Indicators - Not used on Inbound Transmissions	A/N	26		N/A	93	118

Attachment S: Weekly Summary Outbound File Layout

Item #	EDS Data Element/Structure	Field Description	Data Type	Field Length	Edit Format ($zz99.99)	Data Required /Optional	Starting Position	Ending Position
1	SUBMITTAL-ID	'01' = LME 1 '02' = LME 2 '03' = LME 3 '04' = LME 4 '05' = LME 5	A/N	2		Required - Value must be between '01' and '99 and unique to each submitting LME entity	1	2
2	SERVICE TYPE	I = Inpatient (Includes OOS) M = Independent MH O = Outpatient P = PRTF (Includes OOS) R = Residential Child Care (Includes OOS) H = High Risk E = Enhanced Services C = CAP T = Targeted Case Mgmt. D = EPSDT X = Summary Data	A/N	1		Required – must be one of the following: 'I', 'M', 'O', 'P', 'R', 'H', 'E', 'C', 'T', 'D', or 'X'	3	3
3	SUB-SEC-CODE	Submittal Security Code	A/N	4	'LMEI'	Required	4	7
4	STATE-CODE	State Code	A/N	2	'NC'	Required	8	9
5	WE-DATE	Week Ending Date	N	8	MMDDCCYY	Required	10	17
6	TOT-DIS-30	Total Discharges within 30 days	N	7	9999999	Required	18	24
7	TOT-DIS-90	Total Discharges within 90 days	N	7	9999999	Required	25	31
8	TOT-CALLS	Total Calls	N	7	9999999	Required	32	38
9	AVG-ANS-SPEED	Average Speed of answer per 1000 calls	N	7	9999999	Required	39	45
10	ABAN-RATE	Abandonment rate per 1000 calls	N	6	999.999	Required	46	51
11	FILLER	Future use	A/N	41		N/A	52	92
12	REC-ERROR-TABLE	Error Table Indicators – See Appendix I for Error codes	A/N	26			93	118

Attachment T: Weekly Summary Error Codes

Error Number	Error Code	Reason
1	A	The submittal Id is invalid
2	B	The action Id is not 'I' for Inpatient 'M' for Independent Mental Health 'O' for Outpatient 'P' for PRTF 'R' for Residential Child Care 'H' for High Risk 'E' for Enhanced Services 'C' for CAP 'T' for Targeted Case Mgmt. 'D' for EPSDT 'X' for Summary Data
3	C	Submittal Security Code is missing
4	D	State Code is missing or invalid
5	E	Week Ending Date is missing or invalid
6 - 26	F Thru Z	Reserved for additional Summary file edits

Attachment U: Quality of Care Incident Report

Quality of Care Incident Report Form

_____LME

Qualilty of Care Incident Report - Quarterly Update

Reported to DMA between _____ to _____

Provider	MID	Patient Last	Patient First	Treatment	Incident Code	Date Reported to LME
Medicaid Members						

Quality of Care Incident Report Codes

Medicaid Program Incidents
Incident Code Table

Code	*Incident*
1	Adverse Reaction to Treatment
2	Damage to Property
3	Elopement
4	Human Rights Violation
5	Injury
6	Medication or treatment error
7	Other
8	Self-inflicted harm
9	Sexual Behavior
10	Unanticipated Death
11	Violent or assaultive behavior (non-lethal)

Attachment V: Invoice Report Format

Invoice Report Format, page 1

Invoice		
NUMBER	DATE	PAGE
	MAILING DATE	
PO NUMBER	OUR REFERENCE	CUSTOMER
	RALEIGH	

Bill TO

REMIT TO

LINE NO.	DESCRIPTIONS	REVIEWS AND HOURS	RATE USD	AMOUNT USD
	HOSPITAL INPATIENT REVIEWS			
1	CON REVIEW BY FACILITY (INITIAL)			
2	CON REVIEW BY CONTRACTOR (CONCURRENT)			
3	NO CON REQUIRED (INITIAL)			
4	(NO CON) CONCURRENT REVIEWS			
5	RETROSPECTIVE REVIEWS			
	PRTF REVIEWS			
6	ADMISSION REVIEWS			
7	CONCURRENT REVIEWS			
8	RETROSPECTIVE REVIEWS			
	RESIDENTIAL SVCS II-IV REVIEWS			
9	RC LEVEL 1 (ADMISSION)			
10	RC LEVEL 1 (CONCURRENT)			
11	REVIEWS LEVELS II, III, IV 4 BEDS OR MORE			
12	REVIEWS LEVELS II, III, IV 3 BEDS OR LESS			
13	REVIEWS CONCURRENT			
14	RETROSPECTIVE REVIEWS			
	OUTPATIENT REVIEWS			
15	<21 AFTER 26 VISITS			
16	>21 AFTER 8 VISITS			
	SAIOP			
17	ADMISSION REVIEWS			
18	CONCURRENT REVIEWS			
	CRITERION 5 REVIEWS			
19	CRITERION 5			
	COMMUNITY SUPPORTS (CHILD,ADULT & TEAM)			
20	INITIAL REVIEWS			
21	CONCURRENT REVIEWS (EVERY 60 DAYS)			
	INTENSIVE IN-HOME MST			
22	INTENSIVE IN-HOME (ADMISSION)			
23	INTENSIVE IN-HOME (CONCURRENT)			
24	MST (ADMISSION REVIEW)			
25	MST (CONCURRENT REVIEW)			
	OPIOD TREATMENT			
26	INITIAL REVIEWS			
27	CONCURRENT REVIEWS (EVERY 90 DAYS)			

SPECIAL INSTRUCTIONS
Provider No.
Date Range:

SUB TOTAL

Continues on next page

Invoice Report Format, page 2

Invoice		
NUMBER	DATE	PAGE
MAILING DATE		
PO NUMBER	OUR REFERENCE	CUSTOMER
	RALEIGH	

Bill TO

REMIT TO

LINE NO.	DESCRIPTIONS	REVIEWS AND HOURS	RATE USD	AMOUNT USD
	PARTIAL HOSPITAL			
28	PARTIAL HOSPITAL - NO CON (INITIAL & CONCUR)			
29	PARTIAL HOSPITAL - CON (INITIAL & CONCUR)			
	OUT OF STATE PLACEMENT			
30	OUT OF STATE PLACEMENT			
	PSYCHOSOCIAL REHAB			
31	ADMISSION REVIEWS			
32	CONCURRENT REVIEWS			
	DAY TREATMENT FOR CHILD-ADOLESCENTS			
33	ADMISSION REVIEWS			
34	CONCURRENT REVIEWS (EVERY 30 DAYS)			
	ACTT			
35	INITIAL REVIEWS			
36	CONCURRENT REVIEWS (EVERY 30 DAYS)			
	SA COMPRENSIVE OUTPATIENT TX PROG			
37	SA COMPREHENSIVE OUTPATIENT TX PROG (ADMISSION)			
38	SA COMPREHENSIVE OUTPATIENT TX PROG (CONCURRENT)			
	FACILITY-BASED CRISIS			
39	ADMISSION REVIEWS			
40	CONCURRENT REVIEWS			
	AMBULATORY DETOX (NON RES)			
41	ADMISSION REVIEWS			
42	CONCURRENT REVIEWS			
	SUBSTANCE ABUSE, MEDICALLY MONITORED DETOX (RES)			
43	ADMISSION REVIEWS			
44	CONCURRENT REVIEWS			
	QUALITY ASSURANCE REVIEWS			
45	QUALITY ASSURANCE REVIEWS			
	HEARINGS			
46	RECONSIDERATION HEARINGS (**BASED ON HOURS**)			

SPECIAL INSTRUCTIONS
Provider No.
Date Range:

SUB TOTAL

Continues on next page